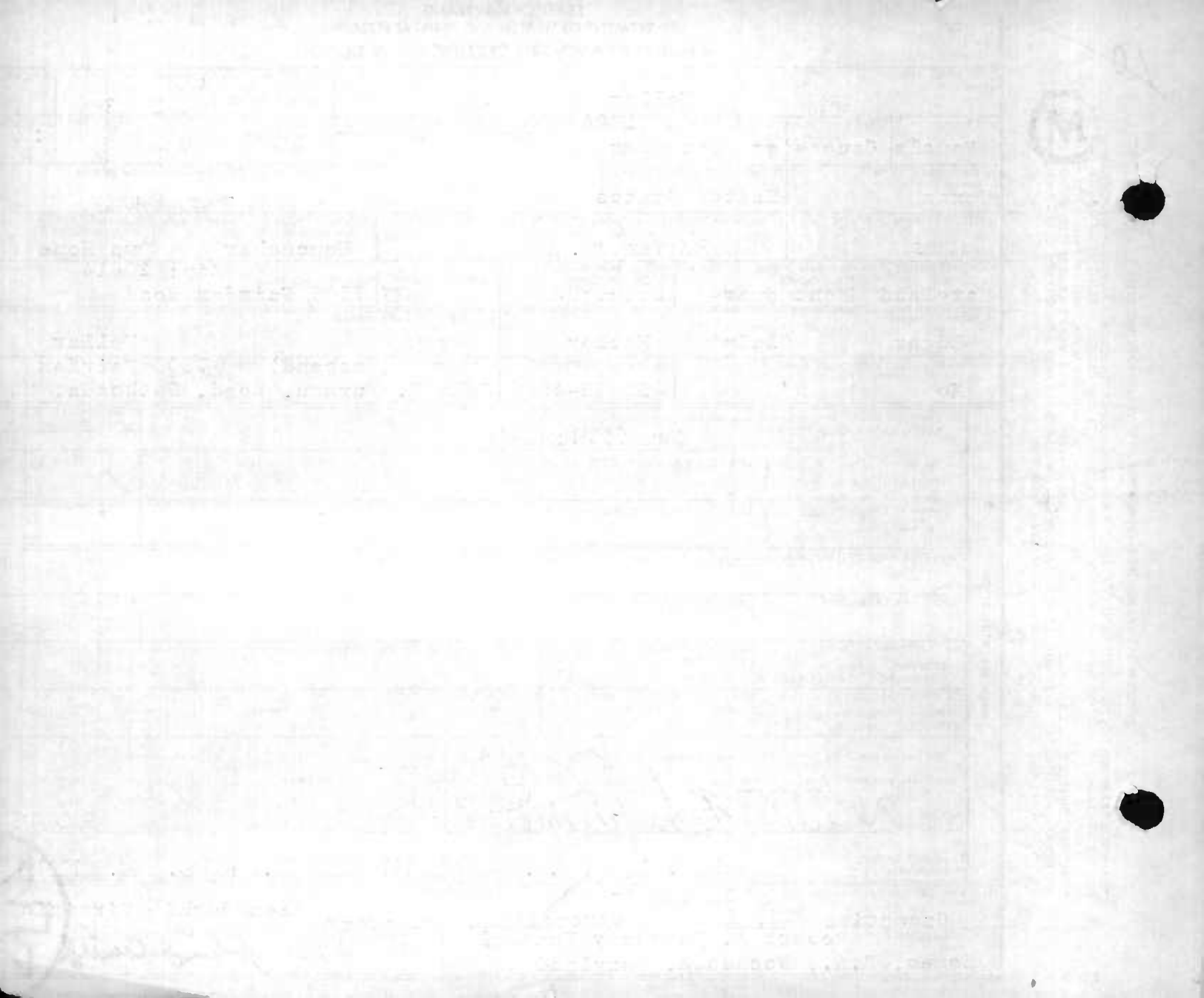


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Erin Weller Furman</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>9/26/83</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>26, 1924</b>	6. AGE (IN YEARS) <b>59</b>	7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	8. IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD <b>9/26/83</b>		2d. HOUR <b>7:00</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7506 Fairfax Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7506 Fairfax Road</b>			
14. FATHER'S NAME <b>Edgar Gleim</b>		15. MOTHER'S MAIDEN NAME <b>Erin Weller</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>452-32-4085</b>		17. INFORMANT (Husband) ADDRESS <b>7506 Fairfax Road, Bethesda, MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Chronic Alcoholism</b> <b>3030</b> IMMEDIATE CAUSE (a) <b>Chronic Alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Chronic Alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Alcoholism</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Dennis F. Smyth, M.D.</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>9/26/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>September 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>				ADDRESS <b>Homes, P.A., Bethesda, Maryland</b>				25a. DATE RECEIVED BY REGISTRAR <b>SEP 30 1983</b>			
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>							



Released by Medical Examiner, Dr. John S. Roge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT) <b>Theobelle S. Gardner</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9/24/83</b>	
3. SEX <b>Female</b>			4. RACE <b>White</b>		2b. HOUR <b>7:25A M</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>2/2/99</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Dakota</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. STATE <b>Md. 20910</b>			13b. CITY OR TOWN <b>Montgomery</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Myron W. Stiles</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Alborn</b>		13c. STREET ADDRESS <b>1515 Dale Drive 20910</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-76-0641</b>		17. INFORMANT ADDRESS <b>Allen H. Gardner. Same as item 13.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST.</b> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRAL VASCULAR ACCIDENT</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY.</b> <b>7 DAY.</b> <b>14 DAY.</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>FRACTURE DISTAL LEFT FEMUR</b>						
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <b>8/26</b> , 19 <b>83</b> , to <b>9/24</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>9/23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not) view the body after death.						
22b. SIGNATURE <b>Alan Jay Diamond</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/25/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN JAY DIAMOND</b>		22e. ADDRESS <b>1106 SPRING ST, SILVER SPRING, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/28/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> NAME ADDRESS <b>5130 Wisc. Ave., N.W. Washington, D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. L...</b>

BP





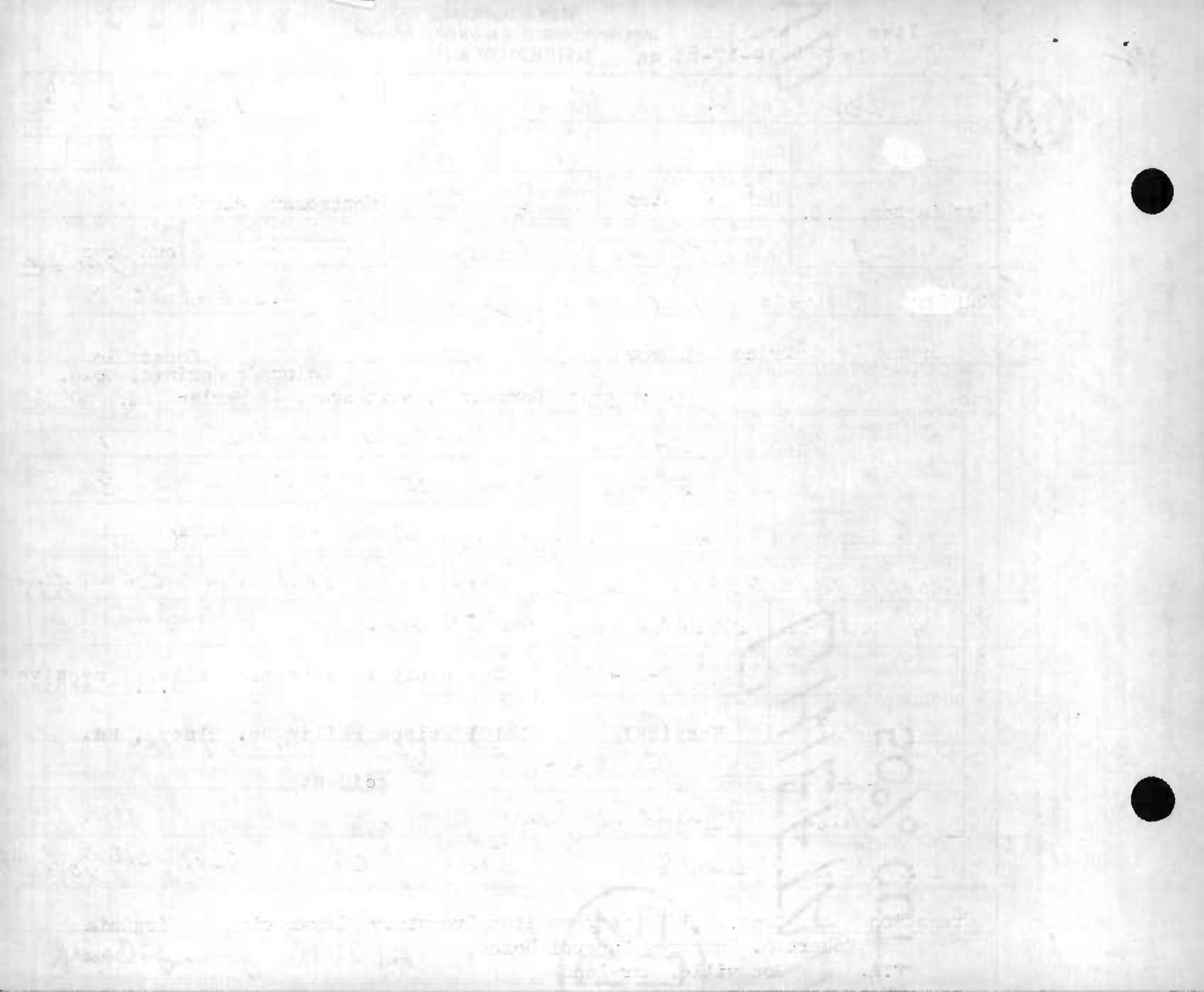
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR Item 21a thru 22a 1- STATE REGISTRAR film 584 10-17-83 cn									
REG. NO. 2 4 8 2 3									
1. DECEASED NAME (TYPE OR PRINT) <b>LOUISE B. GARLAND</b>					2a. DATE OF DEATH MONTH <b>9</b> DAY <b>27</b> YEAR <b>83</b>		2b. HOUR <b>AM</b> MIN <b>11:30</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>18</b> YEAR <b>1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTGOMERY GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>OLNEY</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3650 GLENDALES DRIVE</b>		
14. FATHER'S NAME FIRST <b>Eugene</b> MIDDLE <b>Price</b> LAST <b>Brown</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Belle</b> MIDDLE <b>Constable</b> LAST <b>Colorado Springs, Colo.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>216 40 5356</b>		17. INFORMANT <b>Dorothy G. Hawthorne, 48 Marland Rd., 80906</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b> <b>8768</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ANGIOGRAPHIC DYE, NEPHROSCLEROSIS, EMBOLI</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1</b> <b>3</b> <b>4</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>GASTRIC ULCERS L.G.I. bleeding, MULTIPLE EMBOLI ARTERIAL, GANGRENE FEET.</b>									
19a. DATE OF OPERATION <b>9 24 83</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>EMBOLECTOMY FOR GANGRENE</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. <b>9-23-83</b> MONTH <b>9</b> DAY <b>23</b> YEAR <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Dye study to determine site of massive G.I. bleeding</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Hospital</b>		21f. LOCATION STREET <b>18101 Prince Philip Dr.</b> CITY OR TOWN <b>Olney</b> COUNTY <b></b> STATE <b>Md.</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>9 26 83</b> to <b>9 27 83</b> that (I) (we) lost saw the deceased <b>live on</b> above, (I) (we) <b>did not</b> view the body after death. <b>Accident</b>									
22b. SIGNATURE <b>Oliver J. Lawless</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/28/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OLIVER J. LAWLESS</b>					22e. ADDRESS <b>3701 Rosmoor BLVD. SILVER SPRING 20906</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Sept. 29, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria</b>			23d. LOCATION CITY OR TOWN <b>Virginia</b> COUNTY <b></b> STATE <b></b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Homes, Rockville, Maryland</b>					25a. DATE RECD. BY REGISTRAR <b>SEP 30 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 24824			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Huber Edson Garrett				2a. DATE OF DEATH MONTH DAY YEAR Sept. 1 1983			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 4 1905		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11700 Clopper Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Representative		12b. KIND OF BUSINESS OR INDUSTRY Dairy Co. Greenspring	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John William Garrett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Belle Sparrow		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-26-4960A		17. INFORMANT ADDRESS Pauline M. Garrett 11700 Clopper Rd. Gaithersburg, Md. 20878					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.H.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>49</u> , to <u>Sept. 1</u> , 19 <u>83</u> , that (I) <del>lost</del> saw the deceased alive on <u>Aug. 28</u> , 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.							
22b. SIGNATURE DEGREE <u>Jack Schumacher M.D.</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-2-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.				22e. ADDRESS 105 Russell Avenue, Gaith. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/3/83		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montg. Md.	
24. FUNERAL DIRECTOR <u>Garnett H. Sandison</u> 316 E. Diamond Ave., Gaithersburg, Md. 20877				25a. DATE REC'D. BY REGISTRAR SEP 6 - 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Frances E. Garrison</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 14, 1983</b>		2b. HOUR <b>8:20A M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 13 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) <b>10500 Royal Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alex Dungan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Dickson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Lewis C. Allen-son- (same as 13e)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebrovascular accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1983</b> to <b>Present 1983</b> , that (I) (we) last saw the deceased alive on <b>Sept. 14, 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>David A. Morowitz</b>				22c. DATE SIGNED <b>9-14-1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. DAVID A. MOROWITZ</b>				22e. ADDRESS <b>106 IRVING St. NW-WASH DC 20010</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-17-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Melrose Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Callo Va.</b>
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Constantino G. GEMESIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9 18 83</b>			
3. SEX <b>Male</b>				4. RACE <b>White</b>			
5. DATE OF BIRTH MONTH DAY YEAR <b>4 12 97</b>				6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>86</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>			
13a. STATE <b>MD.</b>				13b. COUNTY <b>Montgomery</b>			
13c. CITY OR TOWN <b>Silver Spring</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>8205 Cedar St.</b>				13f. <b>20910</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George GEMESIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Panagiota Dracopoulos</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-48-9681</b>			
17. INFORMANT <b>Mary E Gemesis. Same as item 13</b>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>5860</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>CARDIAC ARREST HYPERKALEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RENAL FAILURE</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hyperkalemia, severe renal failure, Acidosis</b>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9.7. 1983</b> to <b>9.18. 1983</b> , that (I) (we) last saw the deceased alive on <b>9.17. 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>H. Bahar</b>				DEGREE		22c. DATE SIGNED <b>9.18.83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HADI BAHAR MD</b>				22e. ADDRESS <b>8218 Wisconsin Ave Bethesda MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>9/21/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Maryland.</b>							
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> NAME <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gawler</b>	

BP



[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

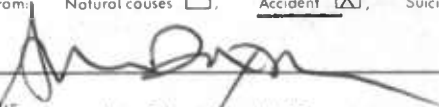
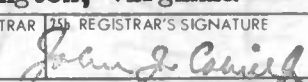
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Jacob Gendler</b>					2a DATE OF DEATH MONTH DAY YEAR <b>September 11, 1983</b>					2b HOUR <b>12:20am</b>
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1888</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Olney</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor (Ret)</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Masonry</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>					13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Sil. Spg.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Gendler</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pina Starkman</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>016-07-2997</b>		17 INFORMANT ADDRESS <b>Pearl Kamber; 3691 So. Leisure World Blvd. Silver Spring, Md.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes, Congestive Heart Failure, Arteriosclerosis</b>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <b>9/6</b> , 19 <b>83</b> , to <b>9/11</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Daniel Goldberg</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c DATE SIGNED <b>9/11/83</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Goldberg</b>		22e ADDRESS <b>3700 Reisterstown Blvd - Silver Spring, Md.</b>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9-13-1983</b>		23c NAME OF CEMETERY OR CREMATORY <b>B'nai B'rith Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Worcester, Massachusetts</b>				
24 FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg</b>		ADDRESS <b>Rockville, Md</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 16 1983</b>		25b REGISTRAR'S SIGNATURE <b>R. E. Connel</b>				

1992

*[Faint handwritten text]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM K GHORMLEY</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>9</b> DAY <b>17</b> YEAR <b>1983</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>29</b> YEAR <b>1905</b>	6. AGE (IN YEARS) LAST (BIRTHDAY) <b>77</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	7c. DATE PRONOUNCED DEAD MONTH <b>9</b> DAY <b>17</b> YEAR <b>1983</b>	24. HOUR <b>4:21</b> P. M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Olney</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Army Officer (Ret)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		
10a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 10a. STATE <b>D.C.</b> 20007				13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3604 Mass Ave., N.W.</b> 99999			
14. FATHER'S NAME FIRST <b>Da vid</b> MIDDLE <b>W.</b> LAST <b>Ghormley</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b> MIDDLE <b></b> LAST <b>Dales</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>W111&amp;Korea</b>		17. INFORMANT <b>Margaretta C Ghormley. Same as item 13</b>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8120</b> IMMEDIATE CAUSE (a) <b>Thoraco-abdominal trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Malignant lymphoma</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>2:44</b> P.M. MONTH <b>9</b> DAY <b>17</b> YEAR <b>1983</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/truck collision.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>			21f. LOCATION STREET <b>Rt. 27 so. of Faith Rd.</b> CITY OR TOWN <b>Montgomery</b> COUNTY <b></b> STATE <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER						DATE SIGNED <b>9-18-83</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/21/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>			23d. LOCATION CITY OR TOWN <b>Arlington, Virginia</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc</b> ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1983</b>			25b. REGISTRAR'S SIGNATURE 		

Page 10 of 10

XX

W.D.A.

London

Army Officer (Gen) U.S. Army

3504 Lane Ave., N.E.

Washington

D.C. 20007

Table

Table

Table

W.

Table

Experiment 2 (Control, same as from 1)

22-22-22

22-22-22

Yes

1000-1000

1000-1000



2/1/73  
Joseph J. ...  
2150 ...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24829

1- FOR  
STATE  
REGISTRAR

REG. NO.

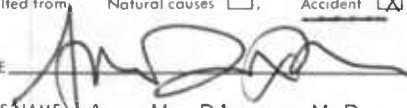

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>ALBERT</b>	MIDDLE <b>GIL</b>	LAST <b>DEN</b>	2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Sept 20 1983</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 1 04 79</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS <b>4 YRS.</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Sept 20 1983</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUTCHER</b>	
12b. KIND OF BUSINESS <b>SAFeway</b>		13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>20910</b>		13f. STREET ADDRESS <b>20910</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>MEDEL GILDEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>BESSIE ZURIFF</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>577-09-7285</b>		17. INFORMANT <b>MRS. GILDA EVANS, 5128 WINNETT ROAD, CHEVY CHASE, MARYLAND</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>						
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <b>DR. JOHN S. ROGERS, M.D.</b>		TITLE (SPECIFY) <b>1919 SEMINARY ROAD SILVER SPRING, MARYLAND</b>		DATE SIGNED <b>Sept 20 1983</b>		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE		
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>9/21/1983</b>		23c. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON D. C.</b>		
24. FUNERAL DIRECTOR <b>STEIN HEBREW MEMORIAL FUNERAL HOME</b>		24a. ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>		24b. DATE REC'D. BY REGISTRAR <b>SEP 23 1983</b>		
24c. REGISTRAR'S SIGNATURE <b>John J. Gough</b>						





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 4 8 3 0	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE (None) GLOVER						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 21 19 83		2b. HOUR 7:28 p.m.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 20, 1900		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 83		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 21 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. STATE NONE						13b. COUNTY NONE		13c. CITY OR TOWN Washington D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leonard (None) Winder						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruthanna (None) Coppock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-24-6173		17. INFORMANT (Nephew) ADDRESS James J. Winder 6204 Windward Pl. Beth. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 4:20 a.m. 9-21- 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by truck.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2600 East-West Hwy., Chevy Chase, Montgomery Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 9-22-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Sept. 23, 83		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Fairfax Virginia	
24. FUNERAL HOME John E. Deibel N.W. Washington D.C.										25a. DATE REC'D. BY REGISTRAR SEP 28 1983	
25b. REGISTRAR'S SIGNATURE 											

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(100)

(100)

Washington, D.C.

Mr. [Name]

(Address)

James J. [Name]

Case #



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24831

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Florence — Goldberg</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 20 83</b>			2b. HOUR <b>3:45 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 18 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Friedman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Herman</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
16a. SOCIAL SECURITY NO. <b>578-16-4508</b>			17. INFORMANT <b>Beatrice Wilder; 12000 Old Georgetown Road, #907; Rockville, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> 9120 DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Aspiration</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12</b> <b>2 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Strokes, ASHD</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/27</b> 19 <b>83</b> , to <b>9/20</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>9/19</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Peter B. Sherer</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>9/20/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER B. SHERER MD</b>				22e. ADDRESS <b>3947 Ferrara Dr. Wheaton md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth Shalom Cong. Cemetery; Capitol Hgts; P.G.; Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>				24b. ADDRESS <b>1170 Rockville Pike; Rockville, Md. 20852</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MURIEL G. GORMLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 1 83</b>			2b. HOUR <b>1750M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 17 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>S.G.A.H. Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Line Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Typewriter</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John - Keppler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Unknown -</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>127-14-5366</b>	
17. INFORMANT ADDRESS <b>10525 Tyler Terrace</b>		18. NAME OF INFORMANT <b>Edward J. Gormley</b>		19. ADDRESS <b>Potomac, Md. 20854</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

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DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Atherosclerotic Heart Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Michael A. Bolognese</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/1/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael A. Bolognese, M.D.</b>		22e. ADDRESS <b>19261 Montgomery Village Ave., Gaithersburg, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/6/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Willow Glen Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dryden Tompkins N.Y.</b>	
24. FUNERAL DIRECTOR NAME <b>Perkins Funeral Home</b>		ADDRESS <b>Dryden, New York</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified apace.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Otto John Gragnani</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9-30-83</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 6 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wheaton Manor Care</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Elec. Eng.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Johns Hopkins A.P.I.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13e. STREET ADDRESS <b>3909 Adams Drive 2902</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Otto John Gragnani</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elvira</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>				16b. SOCIAL SECURITY NO. <b>223-16-3543</b>		17. INFORMANT <b>Julia P. Gragnani</b> ADDRESS <b>Wife Same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NA</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>4-8-83</b> 19____, to <b>9-30-83</b> 19____, that (1) we last saw the deceased living on <b>9-30-83</b> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE <b>Morris Perry</b>				DEGREE <b>Dr. M.D.</b>		22c. DATE SIGNED <b>9-30-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Morris Perry</b>				22e. ADDRESS <b>11602 Georgia Ave Silver Spring Md 20902</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 4, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery Silver Spring Mont Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Hobart Conyers Green</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/23/83</b>			2b. HOUR <b>3:55 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-16-1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1512 Arbor View Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thaddeus C. Green</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Not Available</b>			Zip: <b>20902</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (Son) <b>Carl W. Green</b>		ADDRESS <b>1512 Arbor View Rd Silver Spring, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few days</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus Arteriosclerosis Heart Disease</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> , 19 <b>83</b> , to <b>9/22</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/22/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Antonio G. Uy</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/23/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO G. Uy MD</b>			22e. ADDRESS <b>831 Unit Blvd E #25 S.S. Md 20903</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>September 26, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> ADDRESS <b>P.A., Bethesda, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



INTERNATIONAL EXHIBITION

1904

ST. LOUIS, MO.

(1904)

EXHIBITION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		2b. HOUR
		Ryan Christopher				GREEN	9/21/83		2:19 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
Male		Black		9 20 83		Newborn		Montgomery County	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.A.				n/a		n/a	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12c. INSIDE CITY LIMITS?		13a. STREET ADDRESS		13b. STREET ADDRESS	
Silver Spring		Holy Cross Hospital of Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		324 University Blvd. #532		20905	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
RYAN		CHRISTINE		No		None		Christine Smith-Mother	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> 765D DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extreme immaturity incompatible with life</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22a. DATE SIGNED		22b. REGISTRAR'S SIGNATURE	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		9-21-83		Nelson C. Turcios, MD	
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. REGISTRAR'S SIGNATURE		22e. ADDRESS	
		Nelson C. Turcios		9-21-83		Holy Cross Hosp. Silver Spring Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
Burial		Sept 27, 1983		Harmony Mem. Park		Lanham P.B. City Md.		SEP 29 1983	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE	
W.W. Chambers		Rd 8655 62 Ave		S.S. Md. 20910		SEP 29 1983		Dean J. Conner	

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35A University Blvd. 383 Montgomery Silver Spring a Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Rose Greenbaum				9 24 83 3:50 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		white		1 28 15		68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New York		USA				Montgomery County, Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		Housewife		-----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				13e. STREET ADDRESS			
Maryland Montgomery Sil. Spg.				9119 Manchester Road			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Edward Cooper				Flora (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		053-10-8712		Dr. Larry Greenbaum; 11100 Broadgreen Drive Potomac, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4360</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus, Pneumonia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August 22, 1983</u> to <u>September 24, 1983</u> , that (I) (we) last saw the deceased alive on <u>September 24, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>BARRY HECHT</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>September 25, 1983</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY HECHT</u>				22e. ADDRESS <u>3929 FERRARA DRIVE WHEATON, MARYLAND 20706</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9-26-1983		Hebrew Young Mens Cem.		Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE			
Danzansky-Goldberg Chapels; 1170 Rockville Pike				SEP 28 1983 John J. Canfield			

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RECEIVED  
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20/9/64

10/10/64 10/10/64 10/10/64



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
MARY LOUISE BENSON BROWN GREENE								SEPTEMBER 8 1983				10:20 P <sub>M</sub>							
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
FEMALE		CAUCASIAN		FEBRUARY 8 1910				73		YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
ILLINOIS		UNITED STATES						MONTGOMERY MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NAVAL HOSPITAL										HOUSEWIFE				HOME			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
VIRGINIA		FAIRFAX		FAIRFAX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10411 NELLIE WHITE LANE 99999											
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST RODMAN MERRITT BROWN								FIRST MIDDLE LAST MABLE HELEN BENSON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
NO				459-78-8475				THOMAS J. GREENE, 10411 NELLIE WHITE LANE,											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) MEPASTATIC CARCINOMA OF THE COLON DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 15, 1983, to SEPTEMBER 8, 1983, that (I) (we) lost saw the deceased alive on SEPTEMBER 8, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE J. R. Fletcher										DEGREE		22c. DATE SIGNED 9 Sept 1983							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. FLETCHER MD										22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
Cremation				9-10-83		Metropolitan Crematory				Alexandria, Virginia									
24. FUNERAL DIRECTOR NAME ADDRESS Arlington Funeral Home-Arlington, Virginia										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
										SEP 21 1983		John J. Connel							



Question 2-10-88 Metropolitan Laboratory  
Exhibition General Post Office, Virginia

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BENJAMIN</b>		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR <b>9 13 83</b>				2b. HOUR <b>8:25 AM</b>	
3. SEX <b>M.</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 2 04</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Maryland</b>	
13a. STATE <b>Md.</b>						13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Brentwood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4509 - 40th st 20725</b>	

14. FATHER'S NAME FIRST <b>James E</b> MIDDLE <b>GROSS</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Jane Elizabeth</b> MIDDLE <b>Coater</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Margie Gross James 193 13 E</b>			

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART 1. DEATH WAS CAUSED BY:

 2030 IMMEDIATE CAUSE (a) **MULTIPLE MYELOMA**
APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**2 YEARS**

DUE TO, OR AS A CONSEQUENCE OF

(b)

 Conditions, if any, which  
 gave rise to immediate  
 cause (a), stating the  
 underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
------------------------	--	--	--	---	--	---	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

 22a. I certify that (I) (this hospital) attended the deceased from **9 AUG 1983**, to **13 SEPT 1983**, that (I) (we) last saw the deceased alive on **12 SEPT 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

 22b. SIGNATURE **Walter E. Goetz MD** DEGREE **MD** 22c. DATE SIGNED **13 SEPT 83**

 22d. PHYSICIAN'S NAME (TYPE OR PRINT) **WALTER E. GOETZ MD** 22e. ADDRESS **2309 SHOREFIELD RD SILVER SPRING MD**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>9-16-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, MD</b>	
--	--	-------------------------------	--	---	--	---	--

24. FUNERAL DIRECTOR NAME <b>H. J. Washington &amp; Sons</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carter</b>	
--	--	---	--	---	--

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified after death.

BP

5

Handwritten notes and a table at the top of the page. The table has several columns and rows of data, though the text is mostly illegible due to fading. Some words like "Name", "Age", and "Sex" are faintly visible in the header row.

WILLIAM H. HARRIS

Handwritten notes and a table at the bottom of the page. The table is partially obscured by a large, diagonal, hatched scribble. Some text is visible to the left of the scribble, including what appears to be a date "1911" and some numbers.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lawrence W. Grupenhoff</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 6 1983</b>			2b. HOUR <b>1600 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 8, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bookkeeper</b>		
13a. STATE <b>Ohio</b>			13b. COUNTY <b>Hamilton</b>		13c. CITY OR TOWN <b>Cincinnati</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>45214 2225 Moellering Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Grupenhoff</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Vornhagen</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>270 07 2750</b>		17. INFORMANT <b>Wife</b>				ADDRESS <b>Same as item 13</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

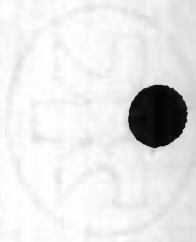
IMMEDIATE CAUSE (a) **Massive Intracerebral Hemorrhage** 3 day  
**4310**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>September 3, 1983</b> to <b>SEP 6, 1983</b> , that (I) (we) lost saw the deceased alive on <b>September 8, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Elba J. Martinez, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/6/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELBA J. MARTINEZ, M.D.</b>				22e. ADDRESS <b>8808 HEDDER HILL LA. - POTOMAC, MD. 20854</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Old Cemetery Cincinnati, Ohio</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 9 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

RECEIVED  
JAN 10 1908  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24840

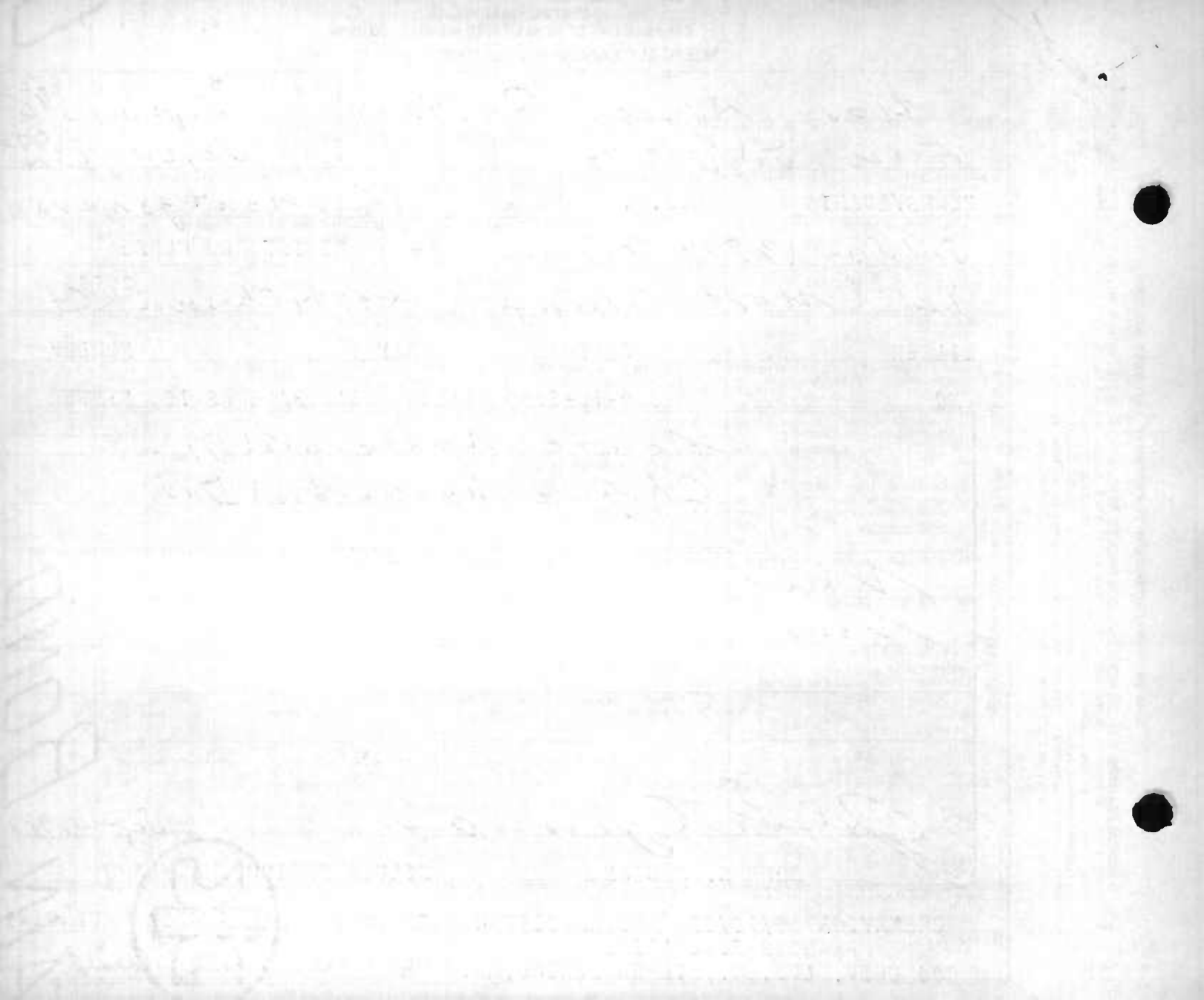
FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Alyce Gunther</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>Sept 11 1983</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>7</b> YEAR <b>1909</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>St. Spg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>3874 Chiswick Ct</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REGISTERED NURSE</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>St. Spg</b>	
14. FATHER'S NAME FIRST <b>WILBER</b> MIDDLE <b>H.</b> LAST <b>GUNTER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE _____ LAST <b>HURLEY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>579-12-5330</b>		17. INFORMANT <b>EILEEN WELLS, SAME AS 13, SISTER</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) <b>Chronic Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D.</b>		MEDICAL EXAMINER <b>John S. Rogers</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>		ADDRESS <b>SILVER SPRING, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>9/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	
500 UNIV. BLVD., W., SILVER SPRING, MD.					

ALEXANDRIA VIRGINIA





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH						
FIRST MIDDLE LAST DOROTHY L. HAGEN					MONTH DAY YEAR SEPT. 3, 1983						
3. SEX					2b. HOUR						
Female					7:34 P.M.						
4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
White		MONTH DAY YEAR April 16, 1916			67 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH						
Washington, D.C.		USA			Montgomery MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Shady Grove Adv. Hospital			H. Maker			Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md. 20878		Mont.		Gaithersburg		YES NO <input checked="" type="checkbox"/>		13000 Brandon Way Rd.			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Clarence L. Linz					FIRST MIDDLE LAST Ethel A. Dyer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
no					218-54-6343		Grant L. Hagen			Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.H.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			21g. DATE SIGNED		
21h. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>49</u> , to <u>9-3</u> , 19 <u>83</u> , that (I) <del>was</del> <u>did</u> view the deceased alive on <u>9-3</u> , 19 <u>83</u> , and that in (my) <del>own</del> <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <u>did</u> view the body after death.			21i. SIGNATURE <u>Jack Schumacher M.D.</u>			21j. ADDRESS Gaithersburg, Md. 20879			21k. DATE SIGNED Sept. 3, 1983		
21l. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jack Schumacher			21m. ADDRESS Gaithersburg, Md. 20879			21n. DATE SIGNED Sept. 3, 1983			21o. DATE SIGNED Sept. 3, 1983		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Mont. Md.				
24. FUNERAL DIRECTOR NAME Francis H. Barber Laytonsville, Md. 20879						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

x

x

A. 24.0

James M. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 24842			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances L. HAINES				Sept. 26, 1983 10:00 A <sub>M</sub>			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Damascus		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 25829 Woodfield Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Schaeffer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Valentine		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-22-0112	
17. INFORMANT ADDRESS 10811 Watkins Rd.		Mrs. Agnes S. Watkins		Germantown, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATO RENAL FAILURE 2° TO METASTASES</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC OAT CELL CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 6 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>11/15</u> , 19 <u>82</u> , to <u>9/26</u> , 19 <u>83</u> , that (I) ( <del>was</del> ) lost saw the deceased alive on <u>9/26</u> , 19 <u>83</u> , and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>provided</del> ) (did not) view the body after death.							
22b. SIGNATURE <u>K. J. Weiss MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/27/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth J. Weiss, M.D.		22e. ADDRESS Damascus Professional Building Damascus, Maryland 20872					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/29/1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Maryland	
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR SEP 29 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Ganiel</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		9		30 83 12 <sup>30</sup> PM	
Albert		Sydney		HAMMOND		SC.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		W		August 27, 1900		83		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md		USA				Montgomery				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Olney, Md.		Brooke Grove Nursing Home		Retired		Auto					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		Montgomery		Olney		YES <input type="checkbox"/> NO <input type="checkbox"/>		20832			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Late John		Late Marie		No		220-30-4523		Mrs Ella Hammond		3412 Folly Quarter Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
PART 1. DEATH WAS CAUSED BY:		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
IMMEDIATE CAUSE (a) 3320				HOUR A.M. MONTH DAY YEAR							
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia				P.M. 19							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE	
				22a. I certify that (I) (this hospital) attended the deceased from 9-28-83, to Sept. 30-83, that (I) (we) lost saw the deceased alive on 9-28-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
				22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
				Eudwich Norman, MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		9-30-83			
				22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		10-3-83		Cedar Hill		Brooklyn					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY BUREAU (FROM REGISTRAR SIGNATURE)		25b. DATE REC'D. BY BUREAU (FROM REGISTRAR SIGNATURE)		25c. DATE REC'D. BY BUREAU (FROM REGISTRAR SIGNATURE)					
NAME		ADDRESS		OCT 6 1983		Anne Arundel					
Harry H Wierke 4112 Columbia Rd Baltimore, Md											

Brooklyn Anna Arnold 19

Cedar Hill

10-3-83

Daniel

Larry H. Wick 4113 Columbia Rd. Mount Pleasant

230-30-4523 Mrs. Elia Hammond 3412 Tolly Quarter Rd

Late John Thomas Hammond Late Marie

Montgomery Olive Brookrove Rd, Olney Md

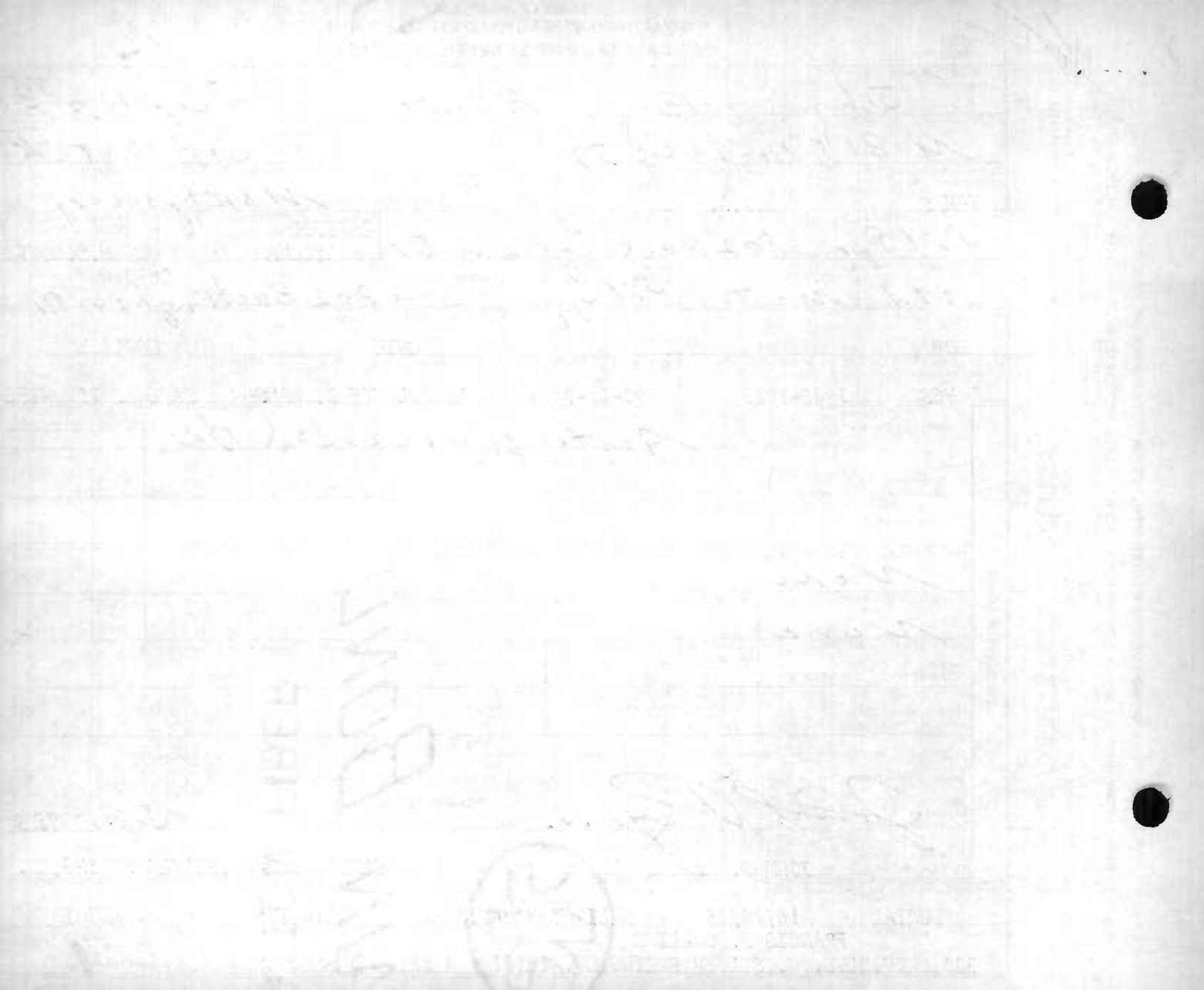
Retired Auto

Montgomery USA

83 August 27, 1900



STATE OF MARYLAND										24844									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH MONTH DAY YEAR									
John B. Hanson										Sept 10 1983									
3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS) (LAST BIRTHDAY) 7c. DATE PRONOUNCED DEAD										7b. HOUR MIN 7d. HOUR MIN									
M BIK Dec 23 23 59 YRS.										5 22 5 22									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED XX NEVER MARRIED WIDOWED DIVORCED										9. BALTIMORE CITY OR COUNTY OF DEATH									
TEXAS U.S.A.										Montgomery MD									
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK CAPABLE OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring 802 Buckingham Dr.										CAPTOL POLICEMAN U.S. GOVT									
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES NO 13e. STREET ADDRESS										20901									
MD Mont Silver Spring										802 Buckingham Dr									
14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																			
BOB HANSON										MOUDIE GODLOCK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS										SAME AS 13 WIFE									
YES 1943-1965 499-14-7456 LIESELOTTE C. HANSON																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4291 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None																			
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO																			
None																			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																			
ACTUAL SIGNATURE TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED																			
EXAMINER'S NAME (TYPE OR PRINT): JOHN S. ROGERS ADDRESS: 1919 SEMINARY ROAD, SILVER SPRING, MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE																			
BURIAL 10/14/83 ARLINGTON NATIONAL ARLINGTON VIRGINIA																			
24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																			
FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 SEP 15 1983 John J. Connel																			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 4 8 4 5	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE ESTIMATED	
IRENE		L.		Hardaway				9 19 83		9 19 83	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
F.	W	3 14 03		80 YRS.						9-23 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		United States		WIDOWED X		DIVORCED		Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		U.S. Government	
Bethesda		10108 Dickens Avenue				Secretary					
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		(20814)	
Maryland		Montgomery		Bethesda		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10108 Dickens Avenue			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Floyd Davis				Hannah Not Available							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				577-60-3746		5200 Russett Road		Archer L. Hardaway		Rockville, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u>											
4029											
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost.											
(b) <u>Hypertensive Heart Disease.</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John D. Amber</u>				M.D. Deputy				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <u>John D. Amber</u>				ADDRESS <u>8218 Wisconsin Ave</u>				DATE SIGNED <u>9-23-83</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				27, 1983		National Mem. Park		Falls Church, Virginia			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Rumphrey Funeral Homes, P.A. Rockville, Maryland 20850						SEP 28 1983		<u>John J. Connel</u>			

BP



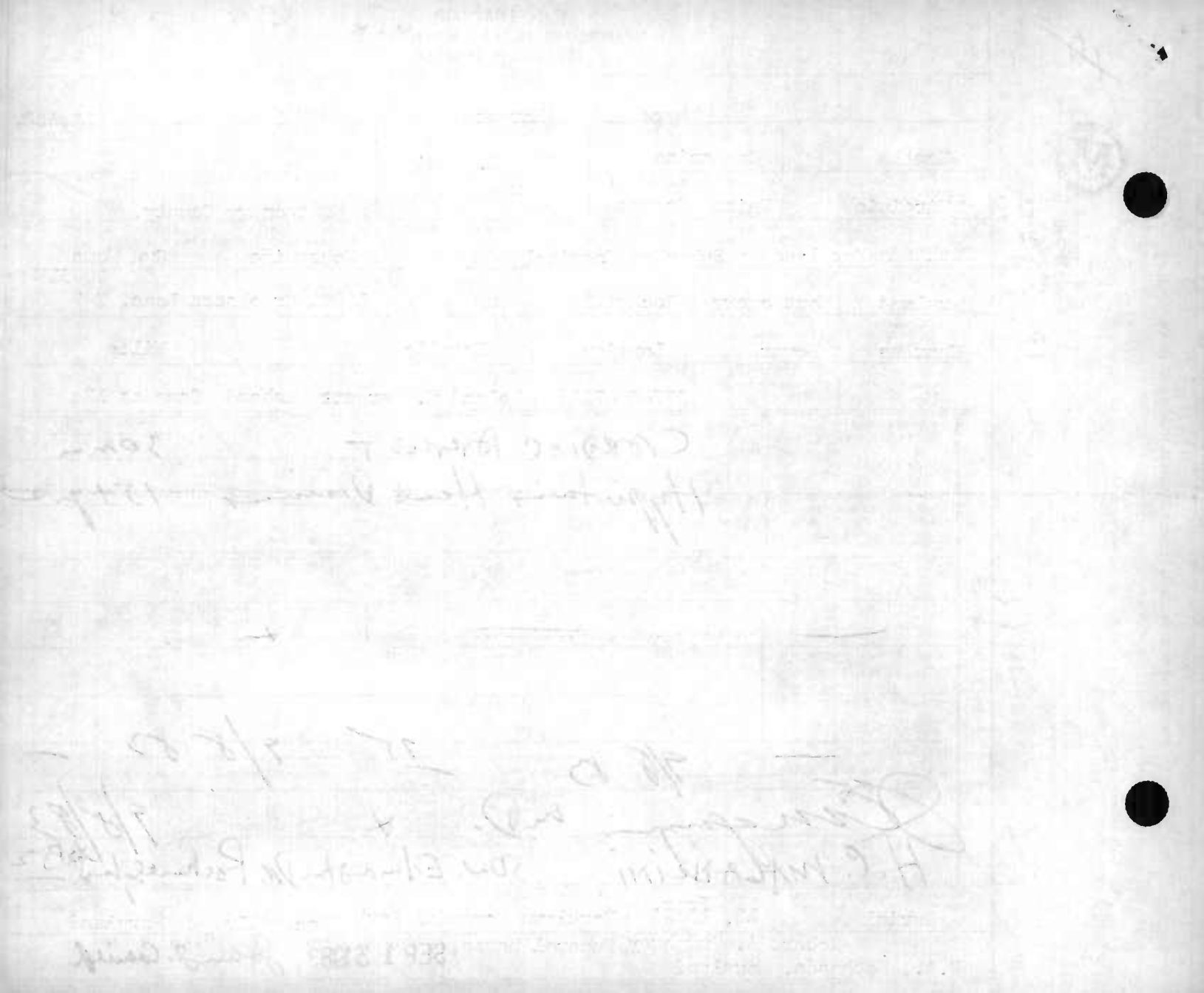
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is ascertained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10-135-1/17

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ellen Myra Hargett					2a. DATE OF DEATH MONTH DAY YEAR 9/8/83			2b. HOUR 12:40 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 12 04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Howard Lovejoy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Miles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-20-7224		17. INFORMANT ADDRESS Roland H. Hargett Husband Same as 13c						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) <u>Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15+ yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased on 9/8/83, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above.										
22b. SIGNATURE OF PHYSICIAN H.C. MAGALINI					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/8/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.C. MAGALINI					22e. ADDRESS 50W. Edmonston Dr. Rockville, MD 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12, Sept. 1983		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey					24b. ADDRESS P.A., Bethesda, Maryland		25. DATE REC'D. BY REGISTRAR SEP 13 1983			
					25b. REGISTRAR'S SIGNATURE Sam J. Canale					



SEP 1 1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LAURETTE J. HARGRAVE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-5-83</b>		2b. HOUR <b>7:10P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 26, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Mont. Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>
13a. STATE <b>VA.</b>	13b. COUNTY	13c. CITY OR TOWN <b>Portsmouth</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>208 Sunrise Ave</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA Bostic</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>414 288699</b>		17. INFORMANT ADDRESS <b>Thomas Hargrave 9015 Garland Ave Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Hemorrhage</b> 4310 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HYPERTENSION</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>August 31, 1983</b> , to <b>September 5, 1983</b> , that (I) (we) lost saw the deceased alive on <b>September 2, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <b>William A. Stern M.D.</b>		DEGREE <b>H.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-6-83</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM A. STERN</b>		22e. ADDRESS <b>14816 PHYSICIANS LANE, ROCKVILLE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9 Sept 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Roosevelt Mem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chesapeake VA.</b>					
24. FUNERAL DIRECTOR <b>W. A. Stern</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1983</b>		25b. REGISTRAR'S SIGNATURE <b>W. A. Stern</b>	



9085

1927

minerals

1442

*[Faint handwritten signature]*

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 3 2 4 8 4 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SOL			2a. DATE OF DEATH MONTH DAY YEAR 9 9 83			2b. HOUR 11 <sup>PM</sup>				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 14 07		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY GPO		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1121 University Blvd. W 20902		
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Harrison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Frank						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Silver Spring, Md. Nathan L. Harrison, 1121 Univ. Blvd. W						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MATTE BLOOD HEMORRAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 days</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Hypertension</u>										
19a. DATE OF OPERATION 9/6/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LEFT AORTA BLOOD HEMORRAGE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/6</u> 19 <u>83</u> to <u>9/9</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Bernard Tjornehoj MD</u>						DEGREE MD		22c. DATE SIGNED 9/9/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD TJORNEHOJ MD						22e. ADDRESS 5530 Wisconsin Ave. Ch. Ch. Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-11-1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery Hyattsville, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				24b. ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR SEP 13 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HAILEGARA

1. FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Stephen J. HAUSER SR</b>		2a. DATE OF DEATH MONTH <b>9</b> DAY <b>25</b> YEAR <b>83</b>		2b. HOUR <b>2:16</b> M
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>OCT</b> DAY <b>20</b> YEAR <b>1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD
10. CITY OR TOWN OF DEATH <b>OLNEY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3725 BRIARS RD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINIST</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>TOOL &amp; DIE</b>

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE <b>MD</b>	13c. COUNTY <b>MONTGOMERY</b>	13d. CITY OR TOWN <b>OLNEY</b>	13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13f. STREET ADDRESS <b>3725 BRIARS RD. 20832</b>
---	--	-------------------------	----------------------------------	-----------------------------------	--	---

14. FATHER'S NAME FIRST <b>LEO</b> MIDDLE <b>HAUSER</b> LAST <b>HAUSER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>KIRCHNER</b> LAST <b>KIRCHNER</b>	
---	--	--	--

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> YES <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>W.W. I</b>	16b. SOCIAL SECURITY NO. <b>196 10 1934</b>	17. INFORMANT <b>STEPHEN J. HAUSER, JR.</b>	ADDRESS <b>2360 Generation Drive Reston, Virginia</b>
---	--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>20 years</b> <b>20 years</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that <b>WR</b> this person attended the deceased from <b>September 19 65</b> to <b>25 September 83</b> , that (we) last saw the deceased alive on <b>22 September 19 83</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (we did not) saw the body after death.	
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22b. SIGNATURE <b>Michael D. Healy MD</b>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9/25/83</b>
--	--------	--	------------------------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael M HEALY MD</b>	22e. ADDRESS <b>5652 Shields Dr. Bethesda, MD 20817</b>
--	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>Sep. 29, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPHS CEMETERY</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANCASTER LANCASTER PENNA</b>
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24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIVERSITY BLVD. WEST, SILVER SPRING, MD. 20901</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1983</b>	25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

X

100  
%



100  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, a medical examination must be notified at once.

*This case referred by Dr. [Signature]*

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR			
Carroll C. HAWKINS					9-27-83					9:00 AM			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Black		NOV. 21, 1920		62 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		U.S.A.				Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital				CONTRACTOR		CONSTRUCTION					
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		13d. INSIDE CITY LIMITS?				
D.C.					NONE		930 3rd. ST. N.W.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
4. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
JULIUS HAWKINS					EMMA BROWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO					213-22-1763		BARBARA WASHINGTON		RT. 2, BOX 2265 LAPLATA, Md. 20646				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY													
9120 IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>										1 hour			
DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>Aspiration (pulmonary)</u>										1 hour 5 min			
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>Generalized seizures</u>										1 hour 5 min			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<u>Chronic Renal Failure, Diabetes mellitus, Anemia, Pseudomonas pneumonia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>Sept 27</u> , 19 <u>83</u> , to <u>Sept 27</u> , 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u>September 27</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.													
22b. SIGNATURE										DEGREE		22c. DATE SIGNED	
<u>James H. Kneppswald, MD</u>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		30 Sept 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS			
<u>James H. Kneppswald, MD</u>										<u>4905 Del Rey Ave, Bethesda, Md 20814</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
BURIAL		10-1-1983		HARMONY MEMORIAL PK.		CITY OR TOWN COUNTY STATE							
						LANDOVER, P.G.C. Md.							
24. FUNERAL DIRECTOR										25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS										D.C.			
W. W. CHAMBERS CO. 517										11th ST. S.E. WASH.		007 4 1983 <u>John J. Connel</u>	

BP

DHMH-16 50M/1 (VRA 15-4)



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a list or table structure.]*



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 TO MEDICAL EXAMINER, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 AND YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. HESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 2/80

FOR Item #6 G584 10/7/83		STATE OF MARYLAND		24851	
1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		20. DATE KNOWN OF DEATH ESTIMATED	
ROGER L HAYTON				9 13 1983	
3. SEX		4. RACE		5. DATE OF BIRTH	
M		CAUC		12 22 46	
6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
38 YRS.					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA		MONTGOMERY	
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rockville		SHADY GROVE ADULTIST HOSP		TRUCK DRIVER	
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. STATE		17. COUNTY	
105-CHAMPLAIN AVE		DEL		NEW CASTLE	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. ADDRESS	
Richard L. Hayton		Linda Mood		24th & Market St. Wilmington, Del.	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		22. SOCIAL SECURITY NO.		23. INFORMANT	
N/A		222-28-6486		Spicer-Mullikin F.H.	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF					
(b) RHEUMATIC HEART DISEASE					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED?		27. AUTOPSY?	
				YES NO	
28. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		29. TIME OF INJURY		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
1004 P.M. 9 13 1983		9 13 1983		COLLAPSED AT WHEEL	
31. INJURY OCCURRED WHILE NOT WHILE AT WORK		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		33. LOCATION	
NOT WHILE AT WORK		STREET		SHADY GROVE GAITHER ROCKVILLE MONTGOMERY	
34. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:					
Natural causes, Accident, Suicide, Homicide, Undetermined manner.					
35. ACTUAL SIGNATURE		36. TITLE (SPECIFY)		37. DATE SIGNED	
Francis C. Mayle		DEPT		9/13/83	
38. EXAMINER'S NAME (TYPE OR PRINT)		39. ADDRESS		40. COUNTY	
Francis C. Mayle		200 Wisconsin Ave. Bethesda MD		Montgomery	
41. BURIAL, CREMATION, REMOVAL (SPECIFY)		42. DATE		43. NAME OF CEMETERY OR CREMATORY	
Burial		9-16-1983		Delaware City Cemetery	
44. FUNERAL DIRECTOR NAME		45. ADDRESS		46. DATE REC'D BY REGISTRAR	
Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		SEP 15 1983	
47. REGISTRAR'S SIGNATURE					
John J. Smith					

Virginia

Delaware

Richard

J.

Robert

W. Allen

Wood

N/A

N/A

212-78-6400

Spicer-Mullikin T.H. Wilmington, Del.

Bertal

2-16-1953

Delaware City Cemetery

Delaware City

Delaware

Lincoln/Ronald Home Silver Spring, Md.

SEP 1

1100 N.E. Ave.

FOR Item 19b & 22a film  
1 - STATE REGISTRAR 584 10-4-83 cn

STATE OF MARYLAND 8-3  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

RFG NC

1. DECEASED NAME (TYPE OR PRINT) <b>Louis J HAZAM</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 6 83</b>		2b. HOUR <b>745</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 03 4</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Conn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Not in such facility</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N.B.C. Producer-Writer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>S.S.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Hazam</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ofifi Habib</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>085 05 5731</b>		17. INFORMANT <b>665 Shannon Dr. Boiling</b> <b>Chad T. Hazam (Son) Springs, Pa. 17007</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>5860</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute respiratory distress syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immune</b> <b>24 hrs.</b> <b>48 hrs.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Renal failure - Rheumatic carditis</b>					
19a. DATE OF OPERATION <b>9-4-83.</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Shunt for dialysis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>renal failure</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>511 83 916 83</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/6</b> 19 <b>83</b> , to <b>9/6</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. <b>Natural</b>					
22b. SIGNATURE <b>James R. Coleman MD.</b>		DEGREE		22c. DATE SIGNED <b>9/6/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES R. COLEMAN</b>		22e. ADDRESS <b>924 COLUMBIA BLVD SILVER SPRING MARYLAND 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/9/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi 11800 N.H.Ave.S.S.Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>S.S. Mont. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>	

10. 11. 1950

54. E. 3. 5. 4.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Francis I. Heinbueh				2a. DATE OF DEATH MONTH DAY YEAR September 16 1983				2b. HOUR 3:14P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 2 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Electrician		12b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 16007 Willow Lane 20853			
14. FATHER'S NAME FIRST MIDDLE LAST John Conrad Heinbueh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Dye							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Goldie Heinbueh Same as item 13 a-e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepato renal syndrome, infection</u> 5712 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Laennec Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic alcoholism</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>diabetes mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-14</u> <u>83</u> to <u>9-16</u> <u>83</u> that (I) (we) lost <u>X</u> saw the deceased alive on <u>9-16</u> <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C Feinstein MD</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9.17.83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Claude Feinstein, M.D.				22e. ADDRESS 18111 Prince Philip Dr. Olney, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-21-83		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Maryland			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR SEP 23 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 24854			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST Carl Heller				SEPT 8, 1983 9:27 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 7, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Produce	
13a. STATE DC 20016 13b. COUNTY None 13c. CITY OR TOWN Washington				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 4427 Neb. Ave. N.W. 99999			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Heller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Schreiber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-30-5324		17. INFORMANT ADDRESS 20833 Brookville, Md. Harry D. Harper/son-in-law/1 Vandever Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 4408 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MO			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11 MAY 19 83 to 8 SEPT 19 83, that (I) (we) last saw the deceased alive on 8 SEPT 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE ATTENDING A MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9 SEPT 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH, M.D.				22e. ADDRESS 2309 Shorefield Road, Wheaton, Md. 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/10/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wash., DC	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 13 1983 [Signature]			



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1- DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH										2b. HOUR	
George J. Herman										9/23 1983										9:45 A.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		7 IF UNDER 1 YR.		7 IF UNDER 24 HRS.		7c DATE PRONOUNCED DEAD		7d HOUR							
Male		White		Mar. 4, 1897		86 YRS.		MONTHS		DAYS		9/23 1983		A.							
8a BIRTHPLACE (STATE OR COUNTY)				8b CITIZEN OF WHAT COUNTRY?				8c MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH									
NEW YORK				U. S. A.								Montgomery County MD									
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY									
Silver Spring				8715 First Avenue, #1209D				SALESMAN				AUTOMOBILE									
13a STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS					
Maryland				Montgomery				Silver Spring				YES XX NO <input type="checkbox"/>				8715 First Avenue, #1209D 20910					
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b SOCIAL SECURITY NO.				17 INFORMANT					
BENJAMIN				HERMAN				BERTHA SILVER				YES				8715 1st AVE					
								WW I				088-10-5941				BERTHA HERMAN, SILVER SPRING, MARYLAND					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY:																					
4291 IMMEDIATE CAUSE (a) Acute myocardial disease.																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
None																					
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?									
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
				P.M. 19				None													
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION													
								STREET CITY OR TOWN COUNTY STATE													
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 9/23/83																					
ACTUAL SIGNATURE John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.																					
23a BURIAL, CREMATION, REMOVAL				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION									
BURIAL				9/26/1983				CEDAR PARK CEMETERY				WESTWOOD COUNTY NEW JERSEY									
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. 25 DATE REC'D. BY REGISTRAR SEP 28 1983 26 REGISTRAR'S SIGNATURE																					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

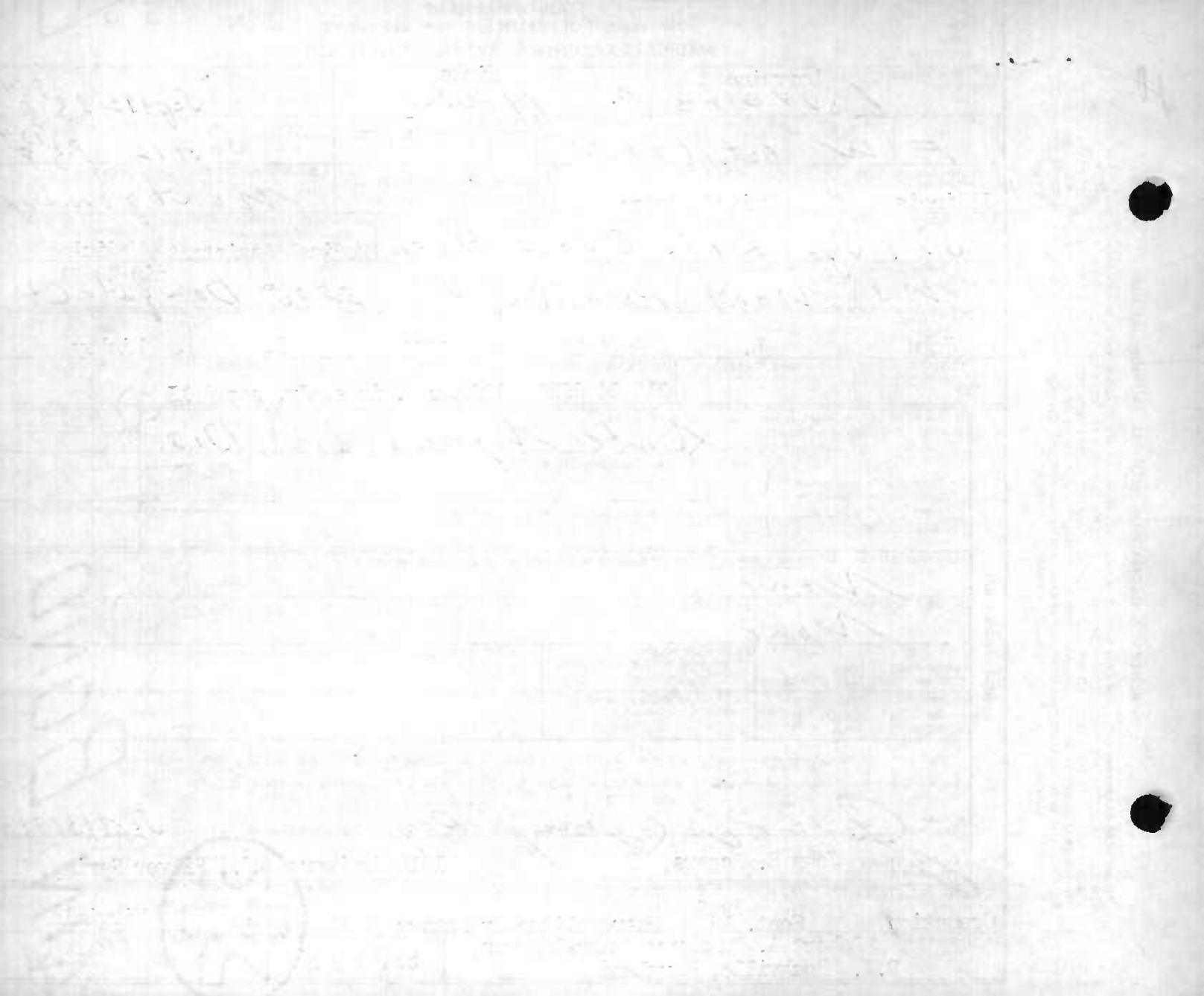
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24856

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lorraine G. Hicks</b>				2a. DATE KNOWN OF DEATH ESTIMATED <b>Sept 12 1983</b>			
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 16 27 52</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>30</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>Sept 12 1983</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Sil Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>High Cross Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Medical Assistant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>Montgomery</b>		13c. STREET ADDRESS <b>5500 Dowgate Ct</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John L. Enfield</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary L. Hickey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218 24 6526</b>		17. INFORMANT ADDRESS <b>Walter W. Hicks, Jr. see # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John S. Rogers, MD</b>		TITLE (SPECIFY) <b>Dep</b>		MEDICAL EXAMINER		DATE SIGNED <b>Sept 13 1983</b> 20910	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <b>1919 Seminary Rd., Silver Spring, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Sept. 14 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ANNIE HIRSCHORN</b>			2a DATE OF DEATH <b>9-23-83</b>			2b HOUR <b>1 P.M.</b>		
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH <b>JUNE</b> DAY <b>15</b> YEAR <b>1900</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.			7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD</b>			10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1001 BROADMORE CIRCLE</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>			12b KIND OF BUSINESS OR INDUSTRY <b>DRESS FACTORY</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>MARYLAND</b> 13c CITY OR TOWN <b>MONTGOMERY BETHESDA</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS <b>10250 WESTLAKE DRIVE 20817</b>		
14 FATHER'S NAME (UNASCERTAINABLE)			15 MOTHER'S MAIDEN NAME (UNASCERTAINABLE)			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b SOCIAL SECURITY NO <b>028-09-2843</b>			17 INFORMANT <b>MRS. EDITH KISSIN, 1001 BROADMORE CIRCLE SILVER SPRING, MARYLAND</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>lymphoma</b> <b>2028</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <b>March 19 83</b> to <b>September 19 83</b> , that (I) (we) last saw the deceased alive on <b>September 22 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)								
22b SIGNATURE <b>James Brodsky MD</b>						22c DATE SIGNED <b>9-23-83</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. JAMES H. BRODSKY, M. D.</b>						22e ADDRESS <b>4701 WILLARD AVENUE SUITE 224 CHEVY CHASE, MARYLAND 20815</b>		
23a BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b DATE <b>9/25/1983</b>		23c NAME OF CEMETERY OR CREMATORY <b>BETH ABRAHAM CEMETERY</b>		23d LOCATION COUNTY <b>EAST BRUNSWICK, NEW JERSEY</b>	
24 FUNERAL DIRECTOR <b>DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>						25a DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>		
25b REGISTRAR'S SIGNATURE <b>Sam E. Cawick</b>								

9-23-83 19

25A

24th Nov 83

1/10/83

x

9-23-83 19  
24th Nov 83  
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30/10/83  
31/10/83

25A



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET MOSS HOLLER</b>					2a. DATE OF DEATH MONTH <b>9</b> DAY <b>17</b> YEAR <b>83</b> 2b HOUR <b>9:15A</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>11</b> YEAR <b>1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CO.</b> MD.			
12. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL LUTHERAN HOME</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		15. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>VIRGINIA</b> 13b. COUNTY <b>SHENANDOAH</b> 13c. CITY OR TOWN <b>CO., EDINBURG</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>R.R. 2</b> <b>99999</b>		
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>S.</b> LAST <b>WEATHERHOLTZ</b>					15. MOTHER'S MAIDEN NAME FIRST <b>OLIVE</b> MIDDLE <b>I.</b> LAST <b>BAKER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>223-50-3252</b>		17. INFORMANT ADDRESS <b>REV. DR. RICHARD REICHARD- NLH- ROCKVILLE, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5324</b> IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bleeding duodenal ulcer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hour</b> <b>5 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>obstructive vascular disease of legs</b>									
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>May 28</b> 19 <b>69</b> , to <b>Sept. 17</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Sept. 17</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Harold F. M' Cann</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9-17-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD F. M' CANN</b>					22e. ADDRESS <b>1355-16th St. N.W. WASH. D.C. 20010</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>SEPT. 20/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETHEL LUTH. CHURCH CEM-</b>		23d. LOCATION CITY OR TOWN <b>HAMBURG,</b> COUNTY <b>VIRGINIA</b> STATE <b>VA</b>		
24. FUNERAL DIRECTOR NAME <b>HYSONG CO., INC.</b> ADDRESS <b>- 1300- N ST., NW WASH., DC</b>					25. DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Shan J. Canfield</b>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE M. HOLTZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/20/83</b>		2b. HOUR <b>1:41pm</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 23, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Thurmont,</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Holtz</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Jamison</b>		13e. STREET ADDRESS <b>12521 Catoctin Furnace Road</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-26-5771</b>		17. INFORMANT ADDRESS <b>Mrs. Mary E. Hurley 5249 E. Wigville Road Thurmont, Maryland 21788</b>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4539**

DUE TO, OR AS A CONSEQUENCE OF

**Acute Thrombotic-Hemorrhagic Brainstem**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

**Hypertension Diabetes**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **9-16-83**, 19**83**, to **9-20**, 19**83**, that (I) (we) last saw the deceased alive on **9-19-83**, 19**83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

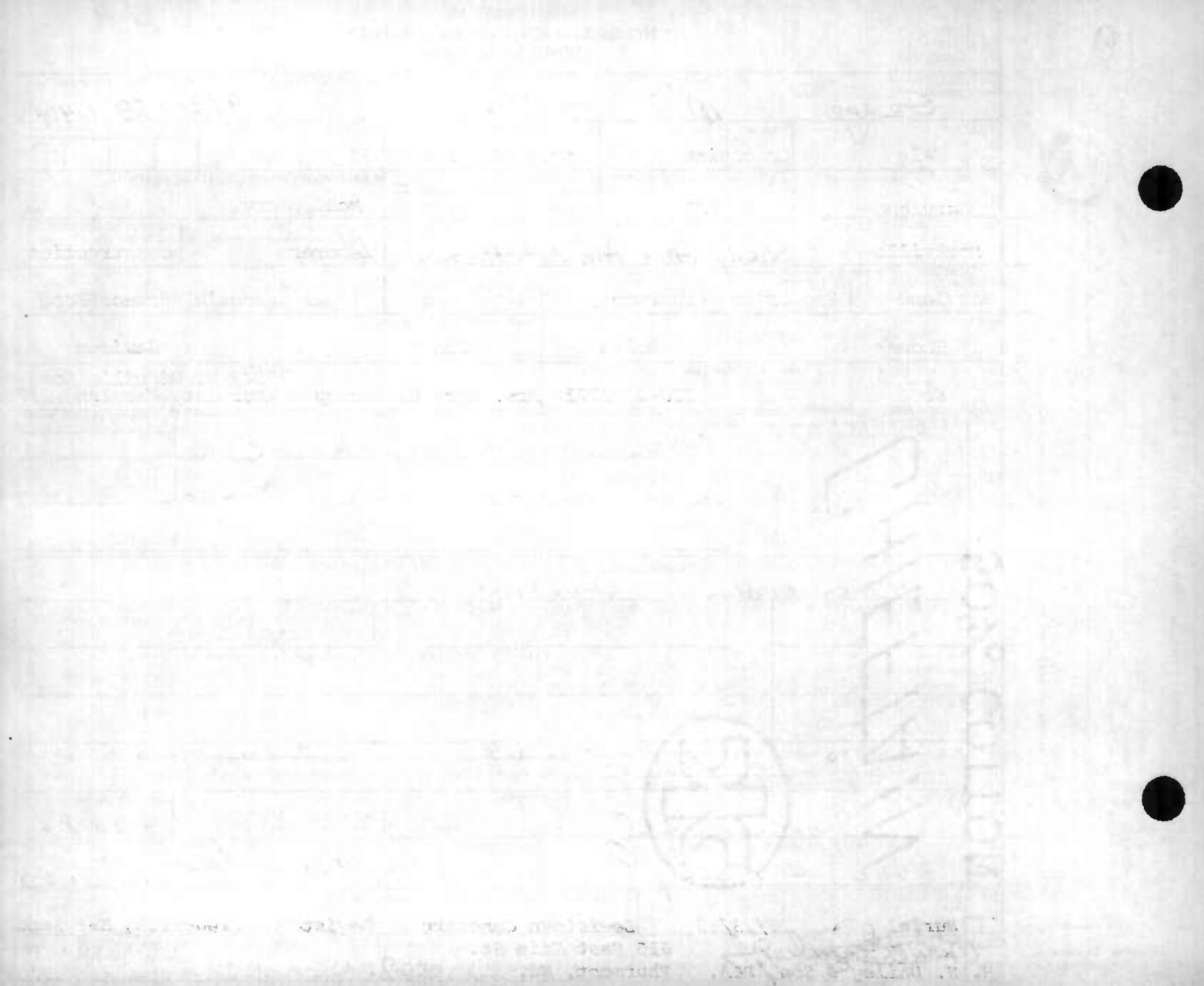
22b. SIGNATURE <b>John E. Kelly MD</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9-20-83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN E. KELLY</b>		22e. ADDRESS <b>Suite 333 9715 Medical Center Dr Rockville MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9/23/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lewistown, Frederick, Maryland</b>
24. FUNERAL HOME <b>R. E. Dailey &amp; Son, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John E. Kelly</b>		25c. REGISTRAR'S SIGNATURE <b>John E. Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 months after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RJ

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>NATHAN HOWARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 1, 1983</b>		2b. HOUR <b>2:20p</b> M
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>December 23, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH, The Clinical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>329 Lincoln Avenue 20850</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick C. Howard</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estelle Prather</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 219-16-8492</b>		17. INFORMANT ADDRESS <b>Rockville, Md. 20850</b> <b>Nathan Howard, Jr. 233 N. Adams St.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Hemorrhagic Consolidating Pneumonitis**

DUE TO, OR AS A CONSEQUENCE OF

**Bilaterally**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Extensive Mediastinal Carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 1, 1983</b> , to <b>September 1, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 1, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.			
22b. SIGNATURE <b>Henry Masur MD</b>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Sept. 2, 1983</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry Masur, MD</b>	22e. ADDRESS <b>National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-7-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Montg. Md.</b>
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 9 1983</b> REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon-copy papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1884



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John Philip Hurley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 - 22 - 83</b>		2b. HOUR A M <b>3:05 A</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 3 1944</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>39</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>	7b. CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mech. &amp; Elec. Inspector AMECOM</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Pr. Geo.</b>	13c. CITY OR TOWN <b>Beltsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>11410 Cherry Hill Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Patrick Hurley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Hudson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>022-32-6971</b>		17. INFORMANT <b>Father</b> ADDRESS <b>1545 Allen St. # 3</b>	
		<b>John P. Hurley</b>		<b>Springfield, Mass. 01119</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

1991

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2wks

1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>15 Nov 82</b> to <b>22 Sept 83</b> , that (2) we saw the deceased only on <b>21 Sept 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.			
22b. SIGNATURE <b>Thomas A. Benninger</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9/22/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS A. BENNINGER</b>		22e. ADDRESS <b>7676 New Hampshire Ave Laurel MD 20703</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sep. 26, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Park Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Springfield Hampden Mass.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis J. Collins</b> <b>500 Univer. Blvd., W. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



1994-1995  
1996-1997  
1998-1999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Roxie M. Imes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-18-83</b>			2b. HOUR <b>3:15 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 28, 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>51</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> NATURALIZED <input type="checkbox"/> BORN <input type="checkbox"/> ALIEN		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Fredrick New Market</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>Box 293, Federal St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nathan Hall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Racheel Thompson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		17. INFORMANT ADDRESS <b>Judy Vinson (daughter) 9408 Newst GARTH, MD.</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INCREASE INTRACRANIAL PRESSURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>MASSIVE INTRACEREBAL HEMORRHAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>SEPT 16 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>#3 WASHINGTON CIRCLE WDC</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 16 1983</b> to <b>SEPT 18 1983</b> that (I) (we) last saw the deceased alive on <b>18 SEPT 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Arthur P. Hustead</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>19 SEPT 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR P. HUSTEAD</b>		22e. ADDRESS <b>#3 WASHINGTON CIRCLE WDC</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-21-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Centerville, Fred. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		ADDRESS <b>2701 N. Wash. ST Rockville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1983</b>		25b. REGISTRAR'S SIGNATURE <b>James G. Canine</b>	

BP

18.5.54

ROYAL M. LINES

Female 1st Class Cabin

Winnipeg, Ont.

Self and 2 children

Age 10, 8 and 5

Travel Agent

10.5.54

10.5.54

10.5.54

10.5.54

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
ANTHONY		IZZO		9-11-83		10:10 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		April 21, 1906		77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Italy		USA				MONTGOMERY CO. MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		SUBURBAN HOSPITAL		Contractor		Self Employed			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md. 20854		Montgomery		Potomac		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9801 Glenolden Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Joseph		Lucia		No		578-42-2057		Dorothy Izzo, Same address as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629		Respiratory failure +		Pneumonia +		COPD		yes 1 wk yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
Pneumonia Septicemia Malnutrition									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
Post op - 12 yr		C & B Lung		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAR 19 83, to 9-11-83, that (I) (we) last saw the deceased alive on 9-11-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	
J. S. SAIA		MD		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
9/13/83		J. S. SAIA		809 Viers Mill Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
Burial		9/15/83		Cedar Hill Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Joseph Gawler's Sons, Inc.		5130 Wisconsin Ave., NW, Washington, D.C. 20016		SEP 19 1983					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detected for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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NAME	DATE	WHITE	BLACK	CONTRACTOR	EMPLOYED
Mr. Robert Montgomery	10/20/57	X		10801 Glenholme Drive	
Joseph	--	Indo	--		10/20/57
no	---	Indo	---	Indo	Indo

*[Faint, illegible handwritten notes and signatures across the middle of the page.]*

2130 Wisconsin Ave., N.W., Washington, D.C. 20005  
Joseph H. Gandy's Sons, Inc.  
Burial: Cedar Hill Cemetery, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the funeral director. Pages 5 and 6 should be retained by the funeral director. Pages 7 and 8 should be retained by the funeral director. Pages 9 and 10 should be retained by the funeral director. Pages 11 and 12 should be retained by the funeral director. Pages 13 and 14 should be retained by the funeral director. Pages 15 and 16 should be retained by the funeral director. Pages 17 and 18 should be retained by the funeral director. Pages 19 and 20 should be retained by the funeral director. Pages 21 and 22 should be retained by the funeral director. Pages 23 and 24 should be retained by the funeral director. Pages 25 and 26 should be retained by the funeral director. Pages 27 and 28 should be retained by the funeral director. Pages 29 and 30 should be retained by the funeral director. Pages 31 and 32 should be retained by the funeral director. Pages 33 and 34 should be retained by the funeral director. Pages 35 and 36 should be retained by the funeral director. Pages 37 and 38 should be retained by the funeral director. Pages 39 and 40 should be retained by the funeral director. Pages 41 and 42 should be retained by the funeral director. Pages 43 and 44 should be retained by the funeral director. Pages 45 and 46 should be retained by the funeral director. Pages 47 and 48 should be retained by the funeral director. Pages 49 and 50 should be retained by the funeral director. Pages 51 and 52 should be retained by the funeral director. Pages 53 and 54 should be retained by the funeral director. Pages 55 and 56 should be retained by the funeral director. Pages 57 and 58 should be retained by the funeral director. Pages 59 and 60 should be retained by the funeral director. Pages 61 and 62 should be retained by the funeral director. Pages 63 and 64 should be retained by the funeral director. Pages 65 and 66 should be retained by the funeral director. Pages 67 and 68 should be retained by the funeral director. Pages 69 and 70 should be retained by the funeral director. Pages 71 and 72 should be retained by the funeral director. Pages 73 and 74 should be retained by the funeral director. Pages 75 and 76 should be retained by the funeral director. Pages 77 and 78 should be retained by the funeral director. Pages 79 and 80 should be retained by the funeral director. Pages 81 and 82 should be retained by the funeral director. Pages 83 and 84 should be retained by the funeral director. Pages 85 and 86 should be retained by the funeral director. Pages 87 and 88 should be retained by the funeral director. Pages 89 and 90 should be retained by the funeral director. Pages 91 and 92 should be retained by the funeral director. Pages 93 and 94 should be retained by the funeral director. Pages 95 and 96 should be retained by the funeral director. Pages 97 and 98 should be retained by the funeral director. Pages 99 and 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR				24864	
1. DECEASED NAME (TYPE OR PRINT) FATHMEH JAVADZADEH			2a. DATE OF DEATH MONTH DAY YEAR Sept 13, 1983		2b. HOUR 12:12 PM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 10 28	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRAN	7b. CITIZEN OF WHAT COUNTRY? IRAN	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY none	
13a. STATE Md		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1001 Rockville Pike, #1304, 20852
14. FATHER'S NAME FIRST MIDDLE LAST unavailable		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unavailable			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Sor Bijan Rastafar	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the esophagus (Adenocarcinoma) 1809 DUE TO, OR AS A CONSEQUENCE OF (b) thrombophlebitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 25, 1983, to Sept 13, 1983, that (I) (we) last saw the deceased alive on Sept 13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Christine L. Wagstaff, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-13-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.L. WAGSTAFF		22e. ADDRESS 1811 Prince Philip Rd Olney Md 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 15, 1983	23c. NAME OF CEMETERY OR CREMATORY Islamic Gardens Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia
24. FUNERAL DIRECTOR NAME James DeVol		DeVol Funeral Home Washington, D.C.		25a. DATE REC'D. BY REGISTRAR SEP 21 1983	25b. REGISTRAR'S SIGNATURE John J. Conner

BP

THE UNIVERSITY OF CHICAGO

Sept. 12, 1988      Island's Gardens Co.,      York Church, Virginia

Isiwa

940 1 3 625



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		2 4 8 6 5	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		2a. DATE OF DEATH	
FIRST MIDDLE LAST LILY JAYSON JAYSON		FEMALE		MONTH DAY YEAR HOUR 09 14 83 9 55 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		4. RACE		6. AGE (IN YEARS LAST BIRTHDAY)	
NEW YORK		WHITE		81 YRS.	
7b. CITIZEN OF WHAT COUNTRY?		5. DATE OF BIRTH		8. IF UNDER 1 YEAR	
USA		MONTH DAY YEAR APRIL 6, 1902		MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
SILVER SPRING		Cherry Chase Nursing Home		Montgomery Co. MD.	
13a. STATE		13b. COUNTY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Maryland		Montgomery		MERCHANT	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		12b. KIND OF BUSINESS OR INDUSTRY	
PHILIP		CELIA		STORE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		579-56-1383		752 GLENEAGLES DRIVE FORT WASHINGTON, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO (b) AS A CONSEQUENCE OF <u>Cerebral Thrombosis Right Hemisphere</u> DUE TO (c) OR AS A CONSEQUENCE OF <u>Generalized Atherosclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>9/12</u> 19 <u>83</u> , to <u>9/14</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (do) examine the body after death.		22b. SIGNATURE <u>Blaine Fitzgerald</u> DR. J. BLAINE FITZGERALD, M. D.		22c. DATE SIGNED 9/15/83.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		9/16/1983		CEDAR HILL CREMATORY	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		SEP 19 1983		<u>John J. Carver</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ERROL W JEFFCOAT</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT. 8 83</b>			2b. HOUR <b>6 P</b> M	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 15 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Derwood</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17816 Mill Creek Dr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>W.S.C.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Derwood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>17816 Mill Creek Dr</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>566-76-0367</b>		17. INFORMANT ADDRESS <b>Mrs. Jeffcoat Derwood MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACTABLE CONGESTIVE HEART FAILURE</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>15 years.</b> <b>4 YEARS.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>RIGHT HEMIPARESIS, JOINT ARTHRITIS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>17 Aug 1960</b> to <b>9/8 1983</b> , that (I) (we) lost saw the deceased alive on <b>Aug 25 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>John J. Fawcett</b>					DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/9/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.C. Helt</b>					22e. ADDRESS <b>Bureau Rd.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>9/9/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithburg</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Smithburg Wash. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>W.C. Helt</b>					25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>SEP 15 1983 John J. Fawcett</b>				

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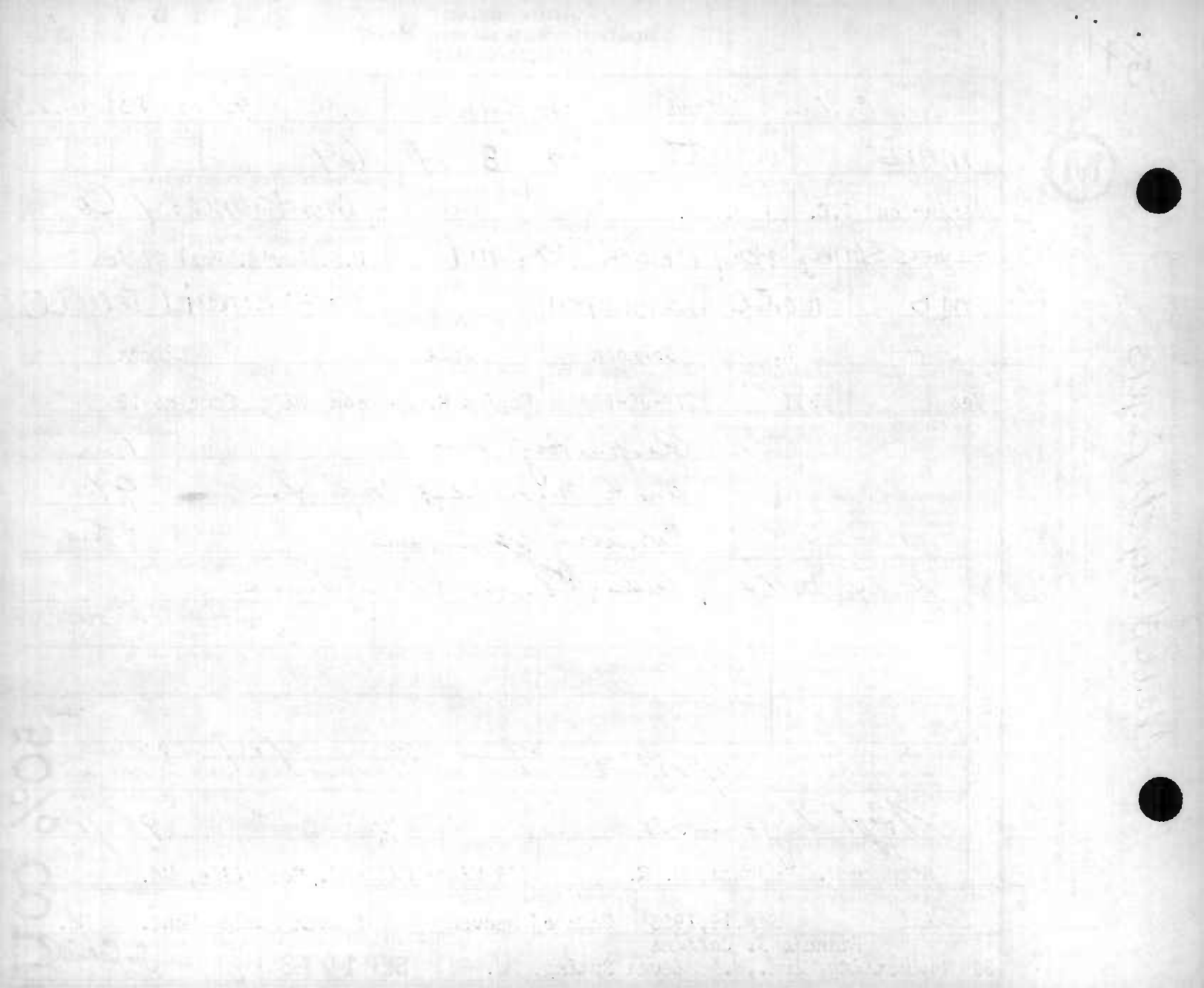
1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Cedric Leland Johnson								9-15-83								3:04 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		IN YEARS (LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		IF UNDER 24 HRS.			
MALE		white		07 18 14		69		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Washington, D.C.		U.S.A.				Montgomery Co										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		Holy Cross Hospital		U.S. Gov't. Post Office													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD		MO. CO		Kensington		YES <input type="checkbox"/> NO <input type="checkbox"/>		3915 Kinraid Terrace									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Edward H. Johnson		Susie Kilmer															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WWII		578-09-8844		Regina M. Johnson		Wife		Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
4100		1 hr.															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		9 hrs															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus, Arteriosclerotic C-V disease</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>3/2/79</u> to <u>9/15/83</u> , that (I) (we) lost saw the deceased alive on <u>9/15/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Stephen N. Jones</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/16/83</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Stephen N. Jones, M. D.		809 Viers Mill Rd. Rockville, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		Sep. 19, 1983		Gate of Heaven		Silver Spring Mont. Md.											
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Francis J. Collins 500 University Blvd., W. Silver Spring, Md.		SEP 19 1983		John J. Lewis													

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 4 8 6 8			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Michael A. Johnson										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 9 1983			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13 1958		6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 9 1983			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		2d. HOUR a. M. 2:10			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Medical Park Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. COUNTY Washington				13c. CITY OR TOWN Washington				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1321 Dexter Terr. S.E. 20020			
14. FATHER'S NAME FIRST MIDDLE LAST Donald A. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy M. Chambers									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-84-8804				17. INFORMANT ADDRESS Lucy Johnson 1321 Dexter Terrace, S.E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wounds of Head 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY est. HOUR A.M. MONTH DAY YEAR 1:00xx 9 9 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Medical Park Dr., Silver Spring, Montgomery Co., Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant M.D.				DATE SIGNED 9-9-83					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 09-15-83		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md.					
24. FUNERAL DIRECTOR NAME Robert G. Mason ADDRESS 1661 Good Hope Road, S.E.						25a. DATE REC'D. BY REGISTRAR SEP 13 1983		25b. REGISTRAR'S SIGNATURE John J. Casper					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					24869					
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Nita Johnson</b>					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <b>9 5 83 5<sup>02</sup> PM</b>					
3. SEX <b>F</b>		4. RACE <b>Blk.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 15 43</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Health Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>WASH. D.C.</b>					13b. COUNTY <b>D.C.</b>		13c. CITY OR TOWN <b>WASH. D.C.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD Johnson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLARA GROOM</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>173-40-6843</b>		17. INFORMANT ADDRESS <b>Clara Johnson, Mother, Detroit, Mich. 48217</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma of Breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>14 months</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>May 19 83</b> to <b>5 September 83</b> that (I) (we) last saw the deceased alive on <b>5 September 19 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John F. Gustafson</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5 Sept. 83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. Gustafson M.D.</b>						22e. ADDRESS <b>5480 Wisconsin Avenue, Chevy Chase, Md. 20815</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>9/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUTCLAND P.G. Md</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Richard Rapp, INC WASH. D.C. 20036</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		

1. The first part of the document is a list of names and their corresponding addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

2. The second part of the document is a table with three columns: Name, Address, and Phone Number. The names are listed in the first column, the addresses are listed in the second column, and the phone numbers are listed in the third column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St. The phone numbers are: 555-1234, 555-5678, and 555-9012.

3. The third part of the document is a list of names and their corresponding addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

4. The fourth part of the document is a table with three columns: Name, Address, and Phone Number. The names are listed in the first column, the addresses are listed in the second column, and the phone numbers are listed in the third column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St. The phone numbers are: 555-1234, 555-5678, and 555-9012.

5. The fifth part of the document is a list of names and their corresponding addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

6. The sixth part of the document is a table with three columns: Name, Address, and Phone Number. The names are listed in the first column, the addresses are listed in the second column, and the phone numbers are listed in the third column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St. The phone numbers are: 555-1234, 555-5678, and 555-9012.

7. The seventh part of the document is a list of names and their corresponding addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

8. The eighth part of the document is a table with three columns: Name, Address, and Phone Number. The names are listed in the first column, the addresses are listed in the second column, and the phone numbers are listed in the third column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St. The phone numbers are: 555-1234, 555-5678, and 555-9012.

9. The ninth part of the document is a list of names and their corresponding addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

10. The tenth part of the document is a table with three columns: Name, Address, and Phone Number. The names are listed in the first column, the addresses are listed in the second column, and the phone numbers are listed in the third column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St. The phone numbers are: 555-1234, 555-5678, and 555-9012.

# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

2 4 3 7 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 02 1983</b>		2b. HOUR <b>0749am</b>
3. SEX <b>FEMALE</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DECEMBER 30 82</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>0 8 03</b>	IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL, BETHESDA</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>BETHESDA</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Norman BEALS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MONICA E JONES</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Monica E. Jones</b>	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIORESPIRATORY ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**40 min****7799**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>30 DEC</b> , 19 <b>82</b> , to <b>2 SEP</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>2 SEPT</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Igor M Gladstone</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>04 SEP 1983</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IGOR M GLADSTONE</b>		22e. ADDRESS <b>NAVAL HOSPITAL DEPT of PEDIATRICS, BETHESDA MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sept. 7 83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Stafford Memorial</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stafford VA.</b>
24. FUNERAL DIRECTOR NAME <b>Bernard O. Ames</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 9 - 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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NOTES

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24871	
1. FOR STATE REGISTRAR										7c. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET R. JONES										2b. DATE KNOWN OF DEATH 09 11 1983	
3. SEX F 4. RACE CAUC 5. DATE OF BIRTH MONTH DAY YEAR 4 5 24 57 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2d. DATE PRONOUNCED DEAD 09 11 1983 6 AM	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN 9b. CITIZEN OF WHAT COUNTRY? U.S.A. 9c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9d. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD										10. CITY OR TOWN OF DEATH BETHESDA 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE 12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE VA 13b. COUNTY FAIRFAX 13c. CITY OR TOWN McLEAN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 6609 FAIRLAWN DR.										14. FATHER'S NAME FIRST MIDDLE LAST ROLLAND RUEHLMAN 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES A. REA	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 577-24-8828 17. INFORMANT ADDRESS HARRIS JONES 6609 FAIRLAWN DR. McLEAN, VA.										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) CIRRHOSIS + LIVER FAILURE 3 YRS DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC ETHANOLISM 1 YRS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 2:00 P.M. 8 18 1983 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AT HOME											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6609 FAIRLAWN DR McLEAN VA											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Francis C. Mayne M.D. TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED 9/11/83											
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayne ADDRESS 600 Wisconsin Ave Bethesda MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 9-15-83 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL 23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA.											
24. FUNERAL DIRECTOR NAME IVEs-PEARSON FUNERAL HOMES ADDRESS ARLINGTON, VA. 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 25b. REGISTRAR'S SIGNATURE											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ABE KANTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 27, 1983</b>		2b. HOUR <b>12:30am</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 22, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lithuania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant (Ret)</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Shoes</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Sil. Spring</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chaim Yosef Kanter</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah (unknown)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW I 297-30-2984</b>		17. INFORMANT ADDRESS <b>Morton M. Kanter; 5103 Sentinel Dr, Bethesda Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>cerebrovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4379 9 days 6 years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Arterio-sclerotic Heart Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>August 9/23</b> , 19 <b>83</b> , to <b>9/27</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jack P. Segal</b>		DEGREE		22c. DATE SIGNED <b>9-27-1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JACK P. SEGAL, M.D.</b>		22e. ADDRESS <b>5530 Wisc. Ave., Chevy Chase, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-28-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Garden</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Va.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1983</b>			
		25b. REGISTRAR'S SIGNATURE <b>John J. Canich</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>REBA</u> MIDDLE <u>M.</u> LAST <u>KAPLAN</u> <u>Reba M. Kaplan</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>SEPTEMBER 22, 1983</u>					2b. HOUR <u>6:45P M</u>
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>APRIL 29, 1897</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>86</u>		IF UNDER 1 YEAR MONTHS DAYS <u>0</u> <u>0</u>		IF UNDER 24 HRS HOURS MIN. <u>0</u> <u>0</u>
7a. BIRTHPLACE (STATE OR FOREIGN) <u>LATVIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY COUNTY</u> MD.				
10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WASHINGTON ADVENTIST HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MARYLAND</u> 13b. PRINCIPAL CITY OR TOWN <u>CHILLUM</u>					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <u>843 COX AVENUE</u>			20783
14. FATHER'S NAME FIRST <u>SAMUEL</u> MIDDLE <u>S.</u> LAST <u>MOREWITZ</u>					15. MOTHER'S MAIDEN NAME FIRST <u>RACHEL</u> MIDDLE <u>(UNASCERTAINABLE)</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NO OR UNKNOWN		16b. SOCIAL SECURITY NO. <u>137-14-7510D</u>		17. INFORMANT <u>MILTON KAPLAN, 843 COX AVENUE, CHILLUM TERRACE, MARYLAND</u>						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Dehydration, Anemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1/83</u> , 19 <u>83</u> , to <u>9/22/83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/22/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>					DEGREE			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VIVEK C VAID</u>					22e. ADDRESS <u>7676 New Hampshire Ave</u>					
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>9/25/1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW CEMETERY</u>			23d. LOCATION <u>HAMPTON, VIRGINIA</u> STATE			
24. FUNERAL DIRECTOR <u>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</u> <u>232 CARROLL STREET, N. W., WASHINGTON, D. C.</u>					25a. DATE REC'D. BY REGISTRAR <u>SEP 26 1983</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

#20c, Film G588 2/2/84  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY		MIDDLE H	LAST KELLER		2a. DATE KNOWN OF DEATH		2b. HOUR		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 09 73		6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 9/17/83 1304	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY		10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE NURSING HOME	
12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D20010		13b. COUNTY		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3105 19th St NW		12b. KIND OF BUSINESS OR INDUSTRY Home	
14. FATHER'S NAME FIRST John		MIDDLE G.		LAST Harris		15. MOTHER'S MAIDEN NAME FIRST Blanche		MIDDLE I		LAST Sims	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 247-12-9739		17. INFORMANT Gilliam Keller		ADDRESS 20155 Hob Hill Way		Gaithersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8842 IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>VOMITING ASPIRATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>FRACTURED RT HIP</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute 1 Hr 13 Days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR A.M. 9 5 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL OUT OF BED							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3105 19th Washington DC							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Francis C. Mayle</i>		EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle		TITLE (SPECIFY) M.D. DEPT		MEDICAL EXAMINER		DATE SIGNED 9/18/83		25. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/21/1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION Brentwood Maryland.		23e. STATE		24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.	
25a. DATE REC'D. BY REGISTRAR SEP 22 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24875

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GARDIE E KERN</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>10</b> YEAR <b>83</b>			2b. HOUR <b>5:13 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>July</b> DAY <b>25</b> YEAR <b>1934</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross HSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>413 Muddy Branch Rd. #T-2</b>	
14. FATHER'S NAME FIRST <b>Willis C.</b> MIDDLE <b>Evans</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Myrtle</b> MIDDLE <b>Helmick</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT <b>Lancaster, Pa.</b> ADDRESS <b>17601 Dewilla Lewis-sister 230 Colonial Crest Dr.</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

1749

IMMEDIATE CAUSE (a)

Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

Acute carcinoma of Breast

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 min.

412.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/10</b> , 19 <b>83</b> , to <b>9/10</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>9/10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. S. Lewis</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/10/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDGAR H. LEWIS</b>				22e. ADDRESS <b>8630 FENTON ST</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9-11-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY <b>20002</b> STATE	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b> NAME <b>300-4th St. N.E. Washington, D.C. 20002</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Sam J. Connel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_



300-45 22.7. Washington, D.C. 20005

229 19 793

Creation 9-11-83  
The funeral home

Les's Crematory

Washington, D.C. 20015

No. 200

222-20-1930 Death-Station 222 Colonial Circle, W.

Washington, D.C. 20015

Marjorie Leland B.

Marjorie L. Evans

Monumentary Cemetery

415 West Branch Rd. W-4

Monumentary

Home

West Virginia

USA

July 29 1983

Death

Time

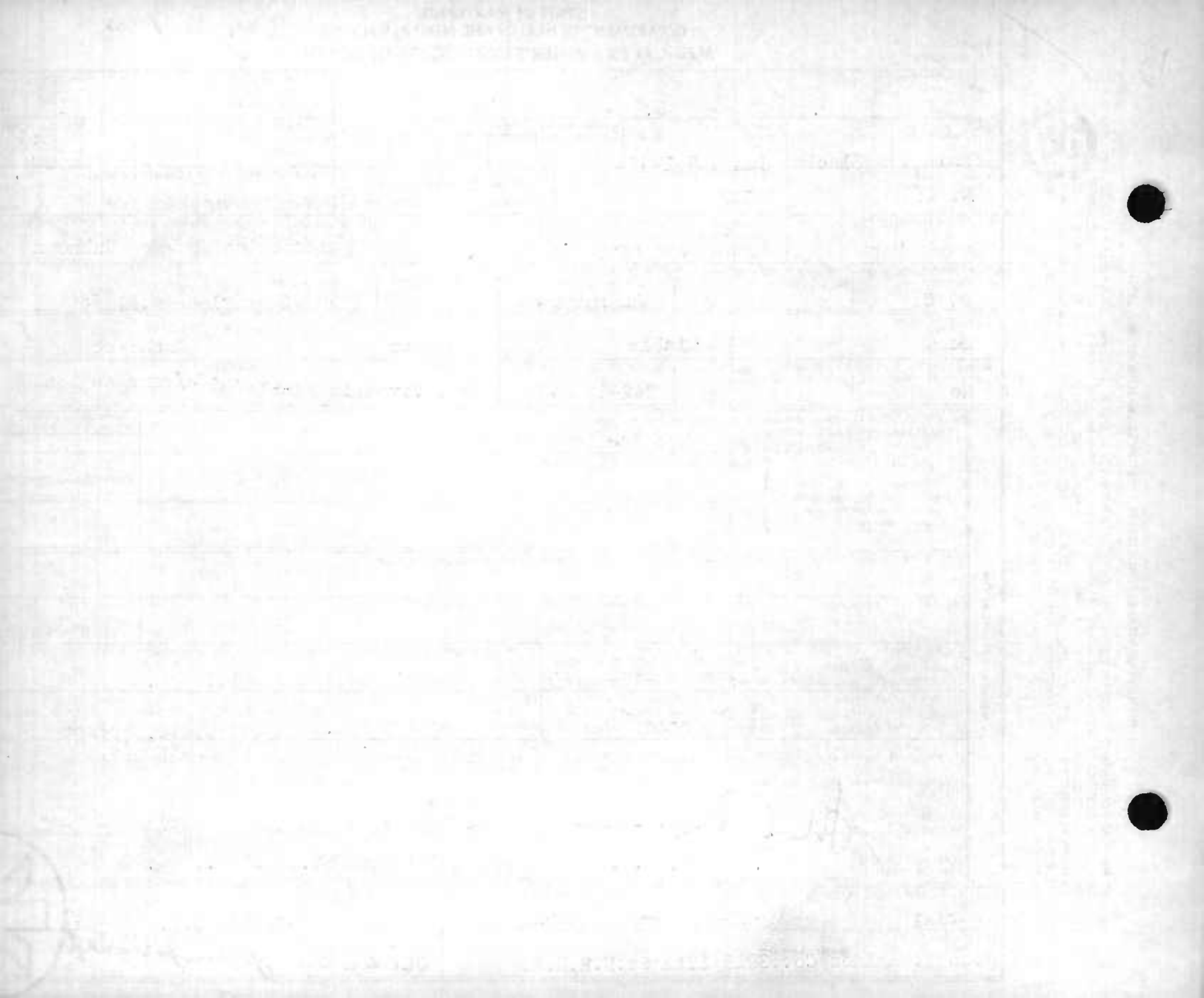
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) D. C. KIMBLE			2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 9 16 19 83			2b. HOUR 5:18 P M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Jun 8 1935	6. AGE (IN YEARS) LAST BIRTHDAY 48 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 9 16 19 83		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Worker		12b. KIND OF BUSINESS OR INDUSTRY Unknown
13a. STATE D. C.			13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Less Kimble			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Cathcart			13d. STREET ADDRESS 1250 simms Place, N.E. #4		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 242-42-6404		17. INFORMANT ADDRESS Mrs. Virginia Kimble/wife/same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8121 IMMEDIATE CAUSE (a). Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR 4:38 P.M. 9-16- 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in auto/bus collision.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE New Hampshire Ave. & Hyattsville, Prince Georges, Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Ann M. Dixon, M.D.			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 9-17-83		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-22-83		23c. NAME OF CEMETERY OR CREMATORY Church		23d. LOCATION CITY OR TOWN COUNTY STATE Gastonia, N.E.	
24. FUNERAL DIRECTOR NAME ADDRESS John T. Rhines Co., 3015 12th St. N.E.D.C.					25a. DATE REC'D. BY REGISTRAR SEP 22 1983			
				REGISTRAR'S SIGNATURE John J. Lohr				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24877

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Emma I KING</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 13 83</i>		2b. HOUR <i>10 58 P.M.</i>		
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 26 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY MD</i>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RETAIL CLERK</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>W &amp; L</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <i>415 SILVER SPRING AVE., 20901</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>DENNIS</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MINNIE MARY SAUL</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	
16b. SOCIAL SECURITY NO. <i>084-03-9677</i>		17. INFORMANT <i>DAUGHTER</i>		17a. ADDRESS <i>4305 54TH PLACE</i>		17b. CITY OR TOWN <i>BLADENSBURG, MD. 20710</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>1889</i> IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Carcinoma of Bladder</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>9/13 19 83 to 9/13 19 83</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/13 19 83</i> and that (I) (we) lost <i>9/13 19 83</i> above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Howard S. Goldstein</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/14/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Howard S. Goldstein</i>		22e. ADDRESS <i>4701 Randolph Rd, Rockville, MD 20852</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>9/17/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>EPIPHANY EPISCOPAL CH.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>FORESTVILLE PRI GEO MD.</i>	
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>		24a. DATE REC'D. BY REGISTRAR <i>SEP 19 1983</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Collins</i>			
25. ADDRESS <i>500 UNIV. BLVD., W. SILVER SPRING, MD. 20901</i>							

BP

THE UNIVERSITY OF CHICAGO  
LIBRARY

1911

1911



THE UNIVERSITY OF CHICAGO  
LIBRARY  
1911



20% COTTON  
ELEVAN

Please for autopsies at Shady Grove

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

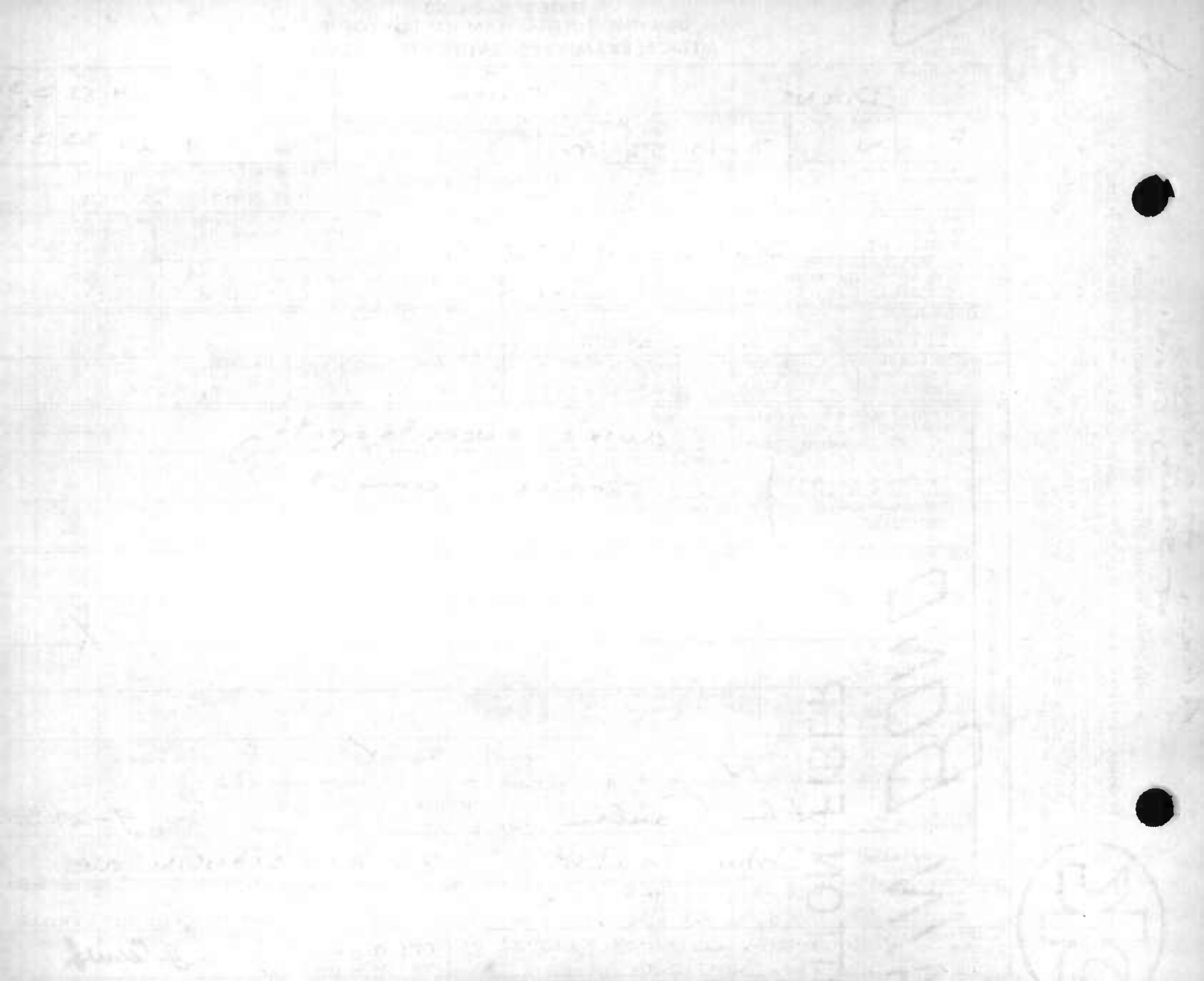
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										24878					
1. DECEASED NAME (TYPE OR PRINT) <b>Diave Klive</b>										REG. NO.					
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 10 53</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>30 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>9 24 83</b>		7b. HOUR <b>3:57</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Health Care</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>916 Bayridge Terrace</b>		Zip: <b>20878</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William D. Kmetz</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Toth</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT (Husband) ADDRESS <b>916 Bayridge</b> <b>Glenn A. Kline, Terr, Gaithersburg</b> MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anoxic encephalopathy</b> 4275 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>John Tauber</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER <b>DATE SIGNED 9-24-83</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b>				ADDRESS <b>8218 Wisconsin ave.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>September 28, 1983</b>		NAME OF CEMETERY OR CREMATORY <b>St Cyril &amp; Methodius</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Windber Pennsylvania</b>							
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes</b>						P.A. <b>Rockville, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carick</b>					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24879

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) T.H. Owen		FIRST T.H.		MIDDLE Owen		LAST Knight		2a. DATE OF DEATH MONTH DAY YEAR 9-4-83		2b. HOUR 28 PM	
3. SEX N		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7-26-04		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY MONT. CO. SCHO			
13a. STATE MARYLAND		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9715 CANEY PL. 20910			
14. FATHER'S NAME FIRST MIDDLE LAST MERRILL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LIZA OWEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 219-36-8352		17. INFORMANT KATHARINE S. KNIGHT				ADDRESS SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic shock 4472 DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Aorto-ENJERIC fistula APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.											
19a. DATE OF OPERATION 9.4.83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aorto-Duodenal fistula				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9.3.83 19 83, to 9.4.83 19 83, that (I) (we) last saw the deceased on 9.4.83 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. Alberto Nunez, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/4/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Alberto Nunez, M.D.				22e. ADDRESS 8218 Wisconsin Ave. Bethesda							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9/5/83		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA ALEXANDRIA VA.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				500 UNIT BLVD W. SIL SPR. MD. 20901				25. DATE REC'D. BY REGISTRAR SEP 13 1983			
				25b. REGISTRAR'S SIGNATURE John J. [Signature]							

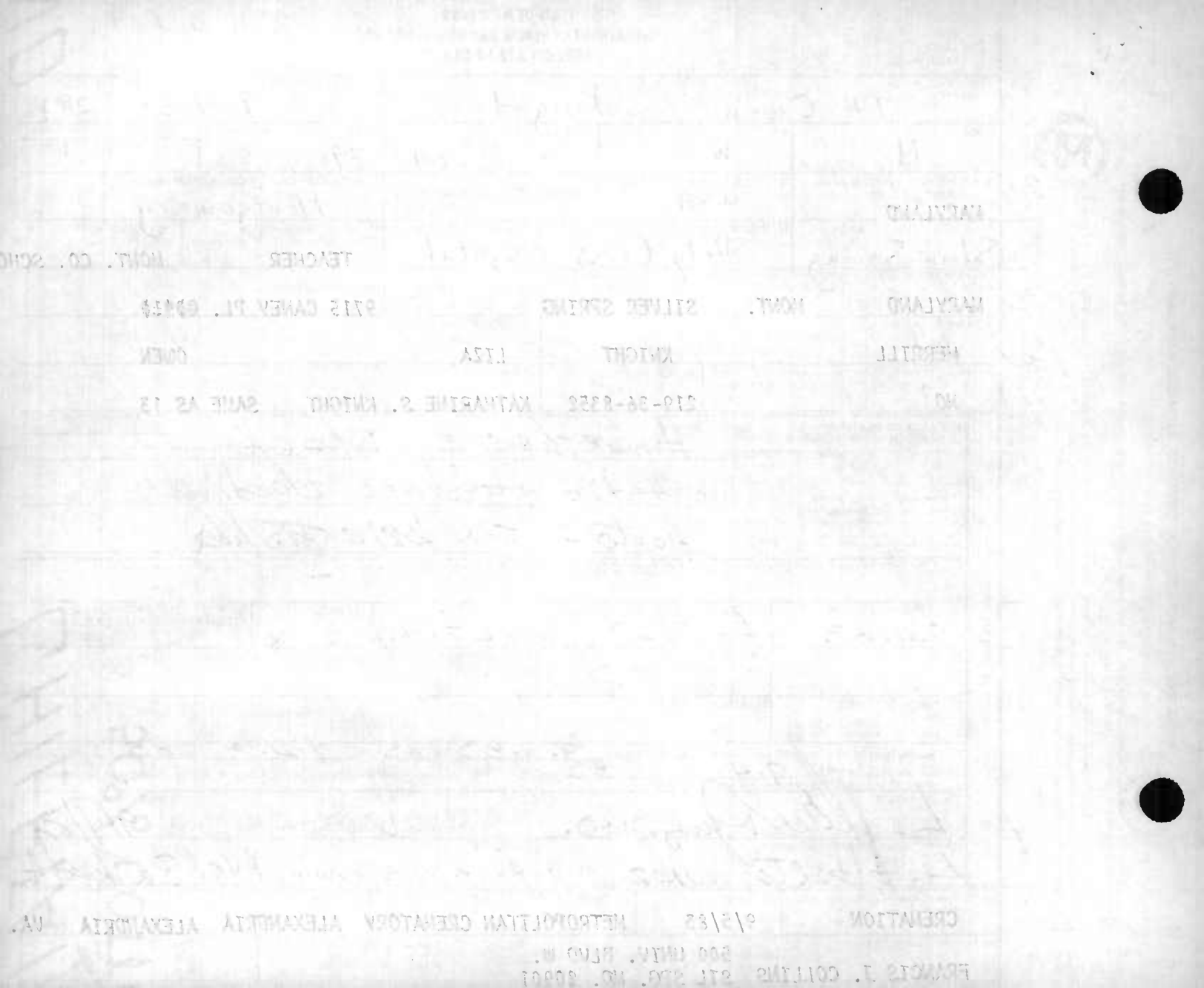
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Lulu - Koch			MONTH DAY YEAR 9/8/83			9:12 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE	WHITE	MONTH DAY YEAR 9/26/1900	82			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
D.C.	U.S.		MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park.	Prince Georges Riverdale		U.S. Civil Svc. Wky. U.S. Gov't.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MD			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5419, Quintana St. 20737		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
(UNKNOWN)		(UNKNOWN)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO		NONE		ROBERT A. CHAMBERS				
		(UNKNOWN)		5803 CLEVELAND AVENUE RIVERDALE, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/30/71</u> , 19 <u>80</u> , to <u>9/7/83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased <u>9/7/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.			22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>9/8/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA			22e. ADDRESS 4404 Queensbury Rd. Riverdale, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL			SEPT/15/83		WASHINGTON NATIONAL		SAITAND P.G. CO. MARYLAND	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
CHAMBERS FUNERAL HOME			SEP 15 1983		John J. Conner			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner number is noted at the top of page 3.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES WILLIAM KOCKA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 11, 1983</b>		2b. HOUR <b>4:00p</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>January 28, 1946</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH, THE CLINICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pipe Fitter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ford Motor Co.</b>
13a. STATE <b>OHIO</b>		13b. COUNTY <b>Medina</b>	13c. CITY OR TOWN <b>MEDINA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3671 NICHOLS RD 44256</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Kocka</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann Tishko</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>270-40-1660</b>		17. INFORMANT ADDRESS <b>MRS. MAUREEN KOCKA (WIFE) SAME 13above</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA AND BRONCHOPNEUMONIA</b> <b>2028</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>NODULAR POORLY DIFFERENTIATED LYMPHOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>2 YEARS</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that ☒ (this hospital) attended the deceased from **August 1, 1983**, to **September 11, 1983**, that ☒ (we) last saw the deceased alive on **September 11, 1983**, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) did not view the body after death.

22b. SIGNATURE <b>George Wilding MD</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>9/12/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE WILDING MD</b>		22e. ADDRESS <b>NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sept 15 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Francis Xavier Cem</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Medina Ohio</b>
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24. FUNERAL DIRECTOR NAME ADDRESS <b>Ives-Pearson F. H. Arlington, VA. 22201</b>	25. DATE RECEIVED BY REGISTRAR <b>SEP 15 1983</b>
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1992



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN B. KOPPMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-28-83</b>			2b. HOUR <b>10<sup>15</sup> A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPTEMBER 20, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME OF GREATER WASHINGTON</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRAVEL AUDITOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3111 PARKER AVENUE 20902</b>	
14. FATHER'S NAME FIRST MIDDLE <b>MAX BRAUTMAN</b>				15. MOTHER'S MAIDEN NAME MIDDLE <b>FANNIE PEARLMAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>102-07-6226</b>		17. INFORMANT ADDRESS <b>MRS. HILDA SINGER, 3111 PARKER AVENUE, SILVER SPRING, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>4408</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>G-ANGRENE OF RIGHT LEG</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>SENILE DEMENTIA</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/28/1976</b> to <b>9/28/1983</b> , that (I) (we) last saw the deceased alive on <b>9/28/1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>D.D. PATEL</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/28/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D.D. PATEL</b>			22e. ADDRESS <b>6121 MONTROSE RD, ROCKVILLE</b>						
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>			23b. DATE <b>10/2/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RIVERSIDE CEMETERY</b>		23d. LOCATION <b>ROCHELLE PARK, COUNTY NEW JERSEY</b>		
24. FUNERAL HOME <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>					25a. DATE REC'D BY REGISTRAR <b>6 1983</b>				
232 CARROLL STREET, N. W., WASHINGTON, D. C.					John J. Gainer				



Printed 8 1930

NOTICE



W. A. R.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 4 8 8 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE James			LAST Koudry			2a. DATE KNOWN OF DEATH MONTH DAY YEAR Sept 19, 1983			2b. DATE OF DEATH MONTH DAY YEAR Sept 19, 1983								
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR May 29, 1925		6. AGE (IN YEARS) (LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Sept 19, 1983			2d. DATE OF DEATH MONTH DAY YEAR Sept 19, 1983								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Safety Engineer				12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS 1107 Loxford Ter.											
13a. STATE MD				13b. COUNTY Montgomery				13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS							
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 547-10-8321						17. INFORMANT Dr. Herbert Koudry Son Same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Chronic Myocardial Dis. yrs (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION None						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE John S. Rogers, M.D.						TITLE (SPECIFY) M.D.						DATE Sept 19, 1983											
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.						ADDRESS 1919 Seminary Rd. Silver Spring, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE Sep. 22, 1983						23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins												25a. DATE REC'D. BY REGISTRAR SEP 26 1983						25b. REGISTRAR'S SIGNATURE John J. Connel					
500 University Blvd., W. Silver Spring, Md.																							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE FILES, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

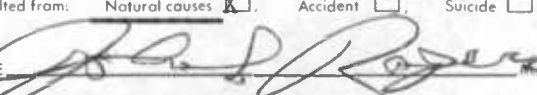

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 4 8 8 4

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 9/18 19 83										7b. HOUR P. M.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert		MIDDLE Irwin		LAST Kronman							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 9/19 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13826 Castle Boulevard, #202				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Manager (Retail) Sears				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20904 13826 Castle Boulevard, #202					
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kronman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Reichgut									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Linda Kronman; 1131 Univ. Blvd., W. #512;		17. ADDRESS Silver Spring, Md. 20902					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a). <u>Acute myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 1919 Seminary Road				DATE SIGNED 9/19/83	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/21/83		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Olney; Montgomery; Maryland			
24. FUNERAL DIRECTOR NAME DANZANKSY-GOLDBERG MEM. CHAPELS 1170 Rockville Pike; Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR SEP 23 1983		25b. REGISTRAR'S SIGNATURE 					



BP  
DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Coral A. Kube				2a. DATE OF DEATH MONTH DAY YEAR Sept. 5, 1983				2b. HOUR 9:30PM	
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Kansas		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Fernwood House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS zip 20814 5015 Battery Lane			
14. FATHER'S NAME FIRST MIDDLE LAST F. A. Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria McQuoid					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 44 7630		17. INFORMANT ADDRESS Katherine K. Grady see # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-VASCULAR COLLAPSE</u> 7970 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADVANCING OLD AGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1WK</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>NO</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1/83</u> 19 <u>83</u> to <u>Sept 5, 1983</u> , that (I) (we) lost saw the deceased alive on <u>9/1/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Leo I. Donovan</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/6/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leo I. Donovan, MD				22e. ADDRESS 8218 Wisconsin Av., Bethesda, Md. 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b. DATE Sept 7, 1983		23c. NAME OF CEMETERY OR CREMATORY Llewellyn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kirkville, Missouri			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				Funeral Home P.A. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 9 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	





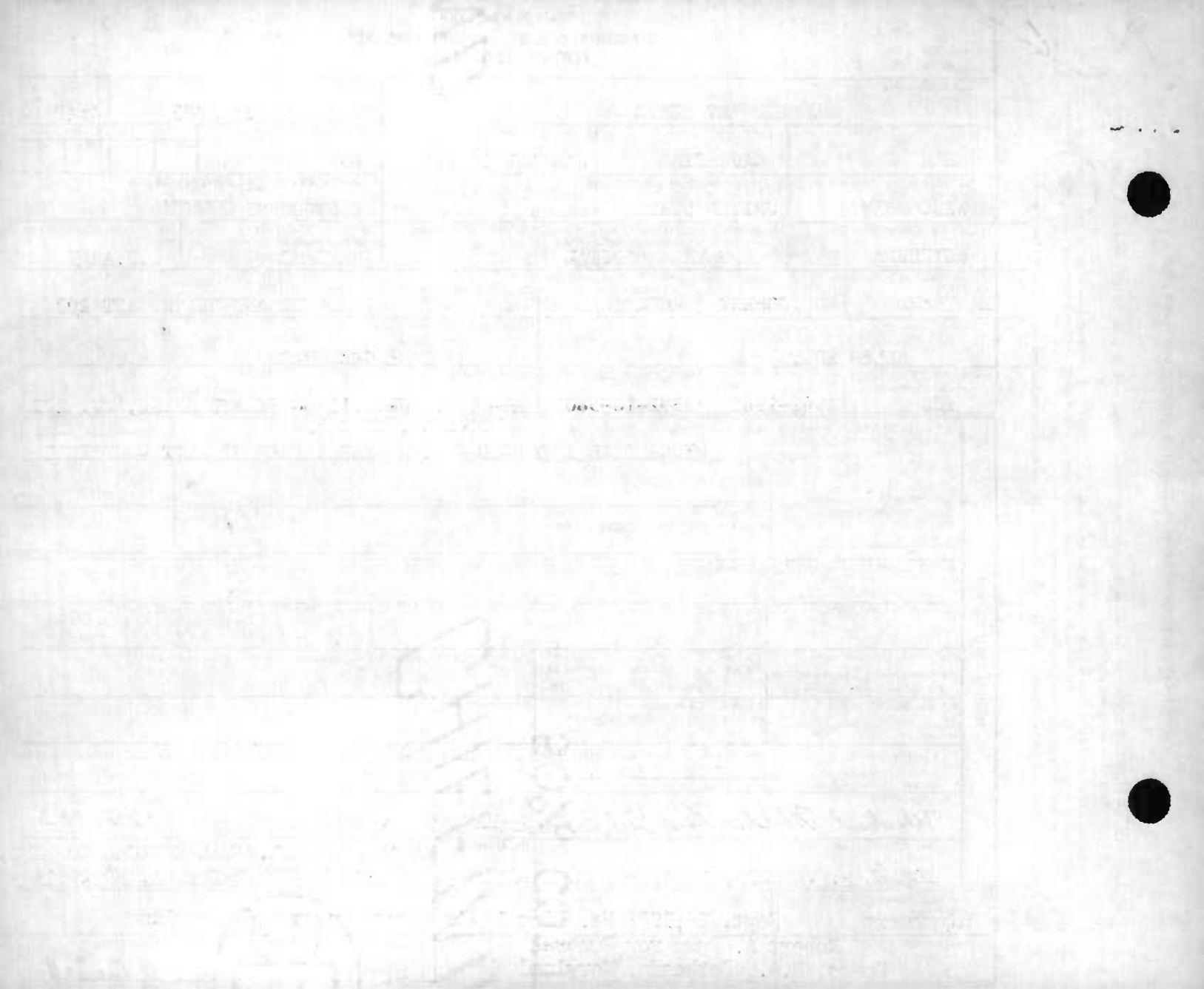
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 24886			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KENNETH RAY KURTZ</b>				2. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 10 1983</b>			
3. SEX <b>MALE</b>				2b. HOUR <b>4:40 P<sub>M</sub></b>			
4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 10 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WISCONSIN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13e. STREET ADDRESS <b>11400 STRAND DRIVE, APT 203</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALLEN KURTZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA GREENHAGEN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1942-1962 392-18-5809</b>		17. INFORMANT ADDRESS <b>GRACE W. KURTZ, 11400 STRAND DRIVE, APT. 203</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION WITH LINEAR TEAR OF LEFT VENTRICLE</b> <b>4148</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 8, 1983</b> , to <b>SEPTEMBER 10, 1983</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael M. Van Ness</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12 Sept 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL M. VANNESS, LCDR, MC, USNR</b>				22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>Sept. 14, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24887

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Lenny			MIDDLE Steven			LAST Langford			2a. DATE KNOWN OF DEATH ESTIMATED 9/24 1983			2b. HOUR 9:29A		
3. SEX M		4. RACE W LK		5. DATE OF BIRTH MONTH DAY YEAR 9/28/17		6. AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD 9/24 1983			7d. HOUR 9:29A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TRINIDAD			7b. CITIZEN OF WHAT COUNTRY? PERM. RES. U.S.A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TAILOR - (RET.)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS 20901 8th St Br Rd Apt 3					
13a. STATE MD		13b. COUNTY MONTG.		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
14. FATHER'S NAME FIRST MIDDLE LAST DARWIN LANGFORD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA SERRETTE														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N			16b. SOCIAL SECURITY NO. 064-52-3671			17. INFORMANT ADDRESS GLADYS LANGFORD (SAME AS #13 ABOVE)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Myocardial Infarction</u> 4920 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <u>Emphysema &amp; Bronchial Asthma</u> Yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John S Rogers			TITLE (SPECIFY) M.D. Dep.			MEDICAL EXAMINER						DATE SIGNED Sept 24/1983					
EXAMINER'S NAME (TYPE OR PRINT) JOHN S ROGERS M.D.			ADDRESS SILVER SPRING MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/28/1983			23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.								
24. FUNERAL DIRECTOR NAME TAKOMA FUNERAL HOME INC.			ADDRESS 254 CARROLL ST. N.W., WASH., D.C. 20001			25a. DATE REC'D. BY REGISTRAR SEP 28 1983			25b. REGISTRAR'S SIGNATURE John J. Carver								

1998年4月

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NANCY JANE LAUGHON					2a. DATE OF DEATH MONTH DAY YEAR September 18, 1983			2b. HOUR 11:20PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 7, 1940		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth., MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1493 Selworthy Rd., 20854			
14. FATHER'S NAME FIRST MIDDLE LAST Bruce Houck			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Houck						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		244-62-4347		17. INFORMANT ADDRESS Mr. Kermit Laughon (Husband) - Same #13a			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>2019</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mediastinal Hodgkin's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <u>he</u> (this hospital) attended the deceased from <u>August 19, 1983</u> to <u>September 18, 1983</u> , that <u>he</u> (we) last saw the deceased alive on <u>September 18, 1983</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>he</u> (we) (did) <u>not</u> view the body after death.									
22b. SIGNATURE <u>Neil J Clendenin MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>9/19/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Neil J Clendenin</u>				22e. ADDRESS National Institutes of Health, Clinical Center, Bethesda, MD 20205					
23a. <del>XXXX</del> CREMATION, <del>XXXXXX</del> (SPECIFY) Cremation		23b. DATE Sept. 20, 1983		23c. NAME OF <del>XXXXXX</del> CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Cedar Hill, P. G. Cty., Md.			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS Co., 8655 Ga. Ave., SS, Md. 209				25a. DATE REC'D. BY REGISTRAR SEP 22 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

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TD HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by direct

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO.		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		Sept.		7,		1983	
Mabel		L.		Leaman								7:20AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
female		white		Nov. 28, 1894		88 YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
South Dakota		United States				Montgomery County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		17305 Twin Ridge Court		Homemaker		Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Germantown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21220 Leaman Lane		20874			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. ADDRESS			
James Moore		Nellie E. Wilson		No		220 44 8164		Daughter Dawn Snow		21220 Leaman Lane		Germantown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Congestive Heart Failure													
4280													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
CVA with right Hemiplegia													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
		HOUR A.M. MONTH DAY YEAR		P.M. 19		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN		COUNTY STATE	
21a. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1983, 19, to Sept. 7, 1983, that (I) (we) last saw the deceased alive on Sept. 5, 1983, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				22c. DATE SIGNED							
Harvey L. Rittenhouse, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				Sept. 7, 1983							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Harvey L. Rittenhouse, MD		13823 Outlet Dr., Silver Spring, MD 20904				Briggs Chaney Plaza							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
Burial		Sept. 9, 1983		Fort Lincoln Cemetery Brentwood, Maryland		CITY OR TOWN							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		SEP 13 1983				[Signature]							



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Marie Lebowitz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 21 83</b>		2b. HOUR <b>1:15AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 21, 1911</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Olney</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		
13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>15210 Elkridge Way, #3-J (20906)</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harris Frank</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Mishamovitch</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-01-1331</b>		
17. INFORMANT ADDRESS <b>Samuel Lebowitz; 15210 Elkridge Way, #3-J;</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra cerebral hemorrhage</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9/19/83</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>9/19/83</b> to <b>9/21/83</b> , that (1) (we) last saw the deceased on <b>9/21/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)					
22b. SIGNATURE <b>John G. Lodmell MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/21/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN G. LODMELL MD</b>		22e. ADDRESS <b>18111 Arvise Philip Dr. Olney Md 20822</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 23, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Gdn.; Falls Church; Fairfax, Va.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <b>John G. Lodmell</b>	
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>		24b. ADDRESS <b>1170 Rockville Pike; Rockville, Md. 20852</b>		25. DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Dong Shen Lee</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9-28-83</i>			2b. HOUR <i>238</i> M				
3. SEX <i>Male</i>		4. RACE <i>Oriental</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 24, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Toy Shan, China</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired-Waiter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Wah Q Restaurant</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wheaton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2705-Hardy Avenue</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Hock Wan Lee</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Wong - See</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			16b. SOCIAL SECURITY NO. <i>164-18-2038</i>		17. INFORMANT <i>Kwok Luen Lee (Son)</i>				ADDRESS <i>Same as #13</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *right cerebral hemorrhage*  
*4310*  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
(b) *Hypertension*  
DUE TO, OR AS A CONSEQUENCE OF  
(c) *Chronic Dementia*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*7 days**years*PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Chronic Dementia*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 21</i> , 19 <i>83</i> , to <i>Sept 28</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive <i>Sept 27</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Mark S. Roen</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>9/28/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mark Rosen</i>				22e. ADDRESS <i>Silver Spring, MD</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Oct. 2, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington National Cem., Suitland, Pr. George, Maryland</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002</i>				25. DATE REC'D. BY REGISTRAR <i>OCT 6 1983</i>			
				26. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY EMMA LEE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 15 1983</b>		2b. HOUR <b>7:31</b> <sup>a</sup> <sub>m</sub>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 13 1914</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ALABAMA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>ALABAMA</b>	13b. COUNTY <b>GENEVA</b>	13c. CITY OR TOWN <b>SAMSON</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>123 S. East Street</b> Zip: <b>36477</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN PARKER RHODES</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY OLLIE STEPHENS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>422-10-4997</b>		17. INFORMANT ADDRESS <b>ROBERT W. LEE, 1504 EAST SELMA, DOTHAN, AL</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> <b>1363</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PNEUMOCYSTIS AND PSEUDOMONOS PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MYCOSIS FUNGIDIES</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 28</b> , 19 <b>83</b> , to <b>SEPTEMBER 15</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>SEPTEMBER 15</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Victor S. Aletich</b> MD LCDR MC USNR		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>16 Sep 83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VICTOR S. ALETICH, LCDR, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sept. 18, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Piney Grove Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Samson Geneva Alabama</b>
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>	25. REGISTRAR'S SIGNATURE <b>John L. Smith</b>
ADDRESS <b>P.A. Bethesda, Maryland</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Handwritten notes and a table at the top of the page. The table has several columns and rows, with some cells containing numbers or symbols. The handwriting is very faint and difficult to decipher.

Handwritten notes and a table at the bottom of the page. The table has several columns and rows, with some cells containing numbers or symbols. The handwriting is very faint and difficult to decipher.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 2 4 8 9 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DORA G. LEVIN			2a. DATE OF DEATH MONTH DAY YEAR September 22, 1983		2b. HOUR 7:30pm
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 2, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY, MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) D.C.			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 2101 16th Street, N.W.
14. FATHER'S NAME FIRST MIDDLE LAST Meyer Bromberg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael (Unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 090-16-7131		17. INFORMANT David Martin; 1500 No. Hancock Street; Arlington		ADDRESS Virginia 22201	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

10 min.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

None

19a. DATE OF OPERATION -----	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (the hospital) attended the deceased from 3/14, 19 83, to 9/22, 19 83, that (I) (we) lost  
saw the deceased alive on 9/22, 19 83, and that in (my) (~~xxx~~) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Raymond Bass MD</i>	22c. DATE SIGNED 9/22/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND BASS	22e. ADDRESS 3929 Ferrara - Wheaton, Maryland 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 25, 83	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi; Prince Georges; Md.
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
1170 Rockville Pike; Rockville, Maryland 20852		SEP 28 1983 J. C. C. C.	

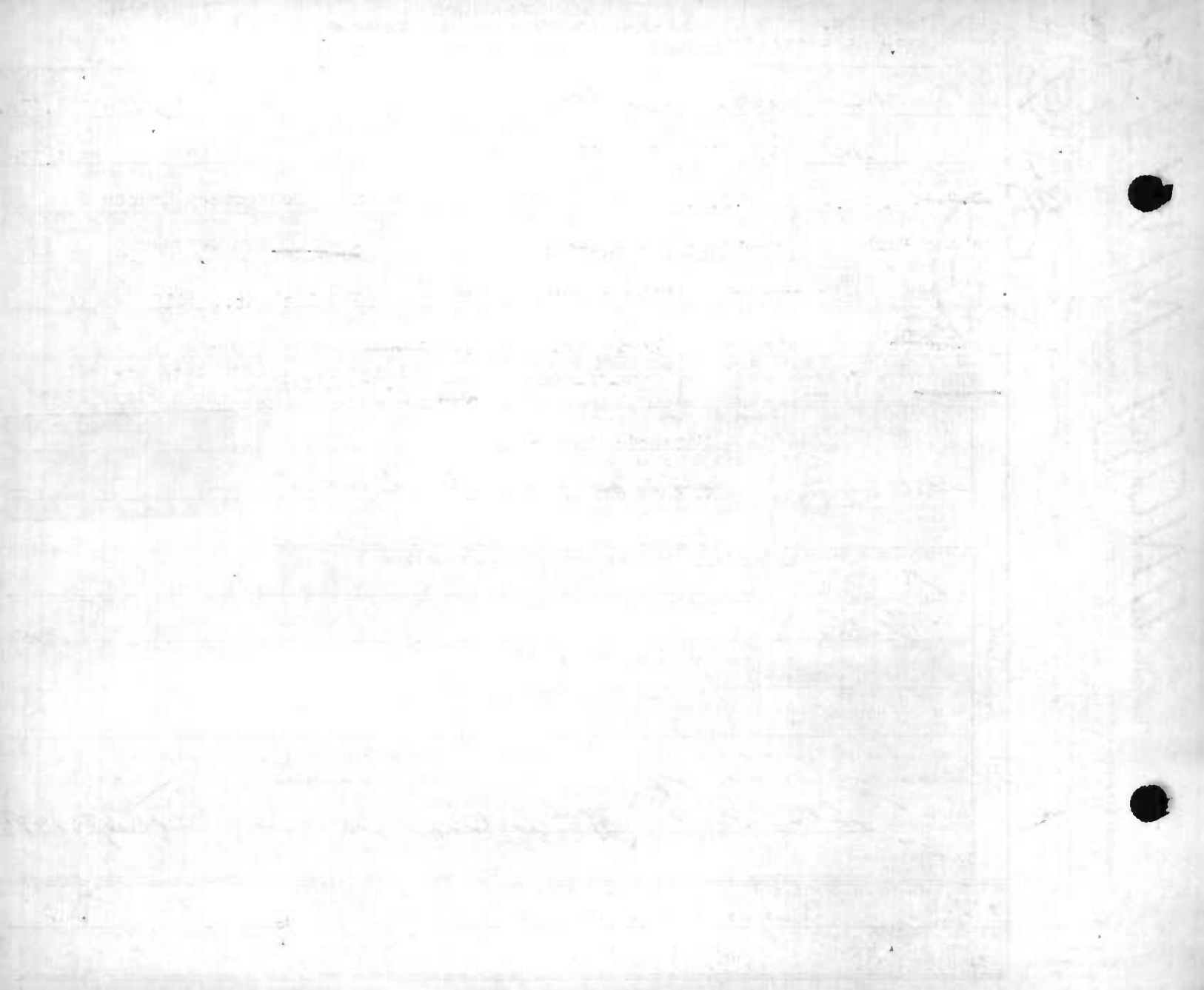
2. Выводы

— 100 —

FOR Item#Info. 1- STATE REGISTRAR Film G585 11/3/83										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Lloyd Richard Lewis Jr.</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 20 1983</b>										2b. HOUR <b>4.47p</b>	
3. SEX <b>M</b>		4. RACE <b>B/K</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 11 38</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>44 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD <b>8 20 1983</b>		2d. HOUR <b>4.47p</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A. W. Va.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>									
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Computer Sr. Engineer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>									
13a. STATE <b>MD</b>				13b. COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>Silver Spring</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>8510 16th St., #415 20910</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Richard Lewis Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>not known Geneva Paden</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes unknown</b>				16b. SOCIAL SECURITY NO. <b>232-56-5943</b>				17. INFORMANT (sister) ADDRESS <b>Sarah L. McMillian 8510 16th St.-#415 Silver Spring, 20910</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1629</b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>																					
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>John P. Rogers</b> M.D. Dep.										TITLE (SPECIFY) <b>M.D. Dep.</b>		MEDICAL EXAMINER		DATE SIGNED <b>Aug 20 1983</b>							
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>Aug 25 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANOVER T.G. MD</b>											
24. FUNERAL DIRECTOR NAME <b>Howe &amp; Davis</b> ADDRESS <b>1432 U ST. N.W.</b>										25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1983</b>		REGISTRAR'S SIGNATURE <b>John J. Connel</b>									

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXCLUDED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be held.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			FIRST MIDDLE LAST Robert G Lewis		MONTH DAY YEAR September 13 83	
3. SEX Male			4. RACE White		5. DATE OF BIRTH	
					MONTH DAY YEAR Dec 4 1919	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC			7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 63	
			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY Maritime Com.			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 9209 Bluebird Terrace			
14. FATHER'S NAME George Thomas Lewis			15. MOTHER'S MAIDEN NAME Mabel Krause			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 578-16-8665		17. INFORMANT Charles F Lewis	
16c. WWII					ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY FAILURE 5400 DUE TO, OR AS A CONSEQUENCE OF (b) PERFORATED APPENDICITIS DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION 9-9-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED APPENDICITIS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9-9-83, to 9-13-83, that (I) (we) lost saw the deceased alive on 9-13-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE IRA MILLER, M.D.				DEGREE M.D.		22c. DATE SIGNED 9-14-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA MILLER, M.D.				22e. ADDRESS 8218 Wisconsin Ave, Bethesda		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 16Sept83		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland
24. FUNERAL DIRECTOR NAME Robert E Wilhelm ADDRESS Suitland Maryland				25a. DATE REC'D. BY REGISTRAR SEP 19 1983		25b. REGISTRAR'S SIGNATURE Joan J. Carver

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UNITED STATES  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C. 20315



CHIEF OF STAFF



SEP 18 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR			REG. NO.			2. DATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY W. LINCOLN			2. DATE OF DEATH MONTH DAY YEAR 9 17 83			2b. HOUR 1711 M					
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9211 Stewartown Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Augustus Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida ?			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.	
17. INFORMANT Barrington Lincoln (son)			ADDRESS Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4273 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterial embolization DUE TO, OR AS A CONSEQUENCE OF (c) atrial fibrillation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7:16 to 9:18, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (by me) (by us) (did I did not) view the body after death.											
22b. SIGNATURE John S. Dolinski			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/18/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Dolinski			22e. ADDRESS 15 E. Deer Pk Dr Gaithersburg Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-22-83		23c. NAME OF CEMETERY OR CREMATORY Asbury Cem.		23d. LOCATION CITY OR TOWN COUNTY Germantown, Montg. Md.				
24. FUNERAL DIRECTOR NAME George R. Snowden			24b. N. WASH. ST. Rockville, Md.		25a. DATE REC'D. BY REGISTRAR SEP 22 1983		25b. REGISTRAR'S SIGNATURE John J. Carver				

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1. The first part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

2. The second part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

3. The third part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

4. The fourth part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

5. The fifth part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

6. The sixth part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

7. The seventh part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

8. The eighth part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

9. The ninth part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.

10. The tenth part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1810, 1811, and 1812.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 24897			
1- FOR STATE REGISTRAR							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Liang Song Liu</b>				2a DATE OF DEATH MONTH DAY YEAR <b>Sept. 6, 1983</b>		2b HOUR <b>11:45 PM</b>	
3 SEX <b>Male</b>		4 RACE <b>Yellow</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Sept. 18, 1921</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>61</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>China</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10 CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9521 Cape Anne Place</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bechtel</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>Maryland</b>				13c CITY OR TOWN <b>Gaithersburg</b>		13d STREET ADDRESS <b>9521 Cape Anne Place 20879</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Unk.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unk.</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>129-30-0866</b>		17 INFORMANT ADDRESS <b>Nancy Liu Same as 13c</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>2030</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Long involvement - Pulmonary tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Myeloma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hours</b> <b>2 years</b> <b>4 years</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>Sept. 20, 1979</b> to <b>Sept 6, 1983</b> , that I (we) <b>last</b> saw the deceased alive on <b>Sept 4, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and frame causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>E.P. Libee</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>7/24/83</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENE P. LIBEE MD</b>				22e ADDRESS <b>10410 CONNECTICUT AVE KENSINGTON, MD. 20895</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b DATE <b>9/7/1983</b>		23c NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Gartner-Sandison Funeral Home 316 E. Diamond Ave. Gaithersburg, Maryland</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>		25b REGISTRAR'S SIGNATURE <b>Sam J. Gainer</b>	

11:45 PM

Sept. 6, 1983

114

Long

114

61

Sept. 18, 1981

Yellow

Male

X

U.S.A.

China

Montgomery

Bechtel

Engineer

9521 Cape Anne Place

Cathernburg

9521 Cape Anne Place 20079

Cathernburg

Mont.

Maryland

Unk.

Unk.

129-30-0866 Nancy Ann Same as 130

No

X

Washington, D.C.

Lee's Observatory

9/1/1983

Observation

Partner-Sandison Tunnel Home

316 E. Diamond Ave. Cathernburg, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Daniel B. Lloyd</b>					2a. DATE OF DEATH MONTH DAY YEAR 9 5 83					
3. SEX <b>Male</b>					4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Professor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>College</b>		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel B. Lloyd</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Belle Gray</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-44-1934</b>		17. INFORMANT ADDRESS <b>Mazie Lloyd 5010 Rockmere Ct. Bethesda Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>3348</b> (b) <b>Progressive Cerebral atrophy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years -</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>weeks -</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 9-4-83 to 9-5-83, that (I) (we) lost saw the deceased alive on 9-4-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Russell M. Tilley, Jr. M.D.</b>					DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Russell M. Tilley Jr. M.D.</b>					22e. ADDRESS <b>4701 Mass. Ave. N.W. Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/8/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Epis. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bowie Prince Georges Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons</b>					5130 Wisc. Ave. N.W. Washington, D.C.		25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gawler</b>	

BP

Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery
Rockville	Montgomery	White	July 1, 1901	Montgomery

The following is a list of the names of the persons who have been  
 admitted to the membership of the Society since the last meeting.  
 The names are given in alphabetical order.

Joseph Gaylor's sons  
 2730 Mac. Ave. N.W.  
 Washington, D.C.

Daniel  
 2/5/1937  
 Holy Trinity Epoc.  
 Howie  
 Prince Georges

Russell H. Wiley Jr. R.  
 4701 Mac. Ave. N.W. Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST LUCILE SNYDER LOHR					MONTH DAY YEAR HOUR 9-26-83 3:45 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
FEMALE		WHITE		March 8, 1908		75		3145	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MONTHS DAYS HOURS MIN.	
Virginia		U.S.A.				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS	
SILVER SPRING		HOLY CROSS HOSPITAL		Teacher		School		14323 Georgia Avenue 20906	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Prince Geo.		Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14323 Georgia Avenue 20906	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Cabet		Lucy		No		578 42 5173		Cabet C. Snyder	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Arrest 4960 DUE TO, OR AS A CONSEQUENCE OF Chronic Asthma Pulmonary Disease 10 y. DUE TO, OR AS A CONSEQUENCE OF Chronic Pulmonary Failure 14 years						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
Right Pt Pneumectomy 1940's ASD CHF									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		22a. I certify that (I) (this hospital) attended the deceased from		22c. DATE SIGNED	
		HOUR A.M. MONTH DAY YEAR P.M. 19		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		saw the deceased alive on 25 Sept 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		26 Sept 83	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS	
WHILE AT WORK <input type="checkbox"/> OR WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Merton L. White M.D.		9911 Georgia Ave Silver Spring Md 20902	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		25a. DATE REC'D. BY REGISTRAR	
Burial		9/28/83		Ft. Lincoln Cemetery		Brentwood P.G. Maryland		25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home, P.A.									
Hyattsville, Maryland									

20AN<sup>®</sup> COLLEOM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET LONG</b>			2b. DATE OF DEATH MONTH DAY YEAR <b>9/14/83</b>			2c. HOUR <b>7 45 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 3 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Kensington</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Circle Manor Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P. G.</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5606 Queens Chapel Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick Long</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice M. Wilson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Frank J. Storke Annapolis, Md. 21404</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebrovascular insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Diabetes, senile emaciation, coronary insufficiency**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **April 25, 1979** to **9/14, 1983**, that (I) (we) last saw the deceased alive on **9/14, 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) not view the body after death.

22b. SIGNATURE <b>Martin C. Shargel</b>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9/14/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN C. SHARGEL</b>		22e. ADDRESS <b>3720 FARRAGUT AVE KENSINGTON, MARYLAND-20895</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-17-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D. C.</b>
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24. FUNERAL DIRECTOR NAME <b>Francis Gasch' Sons P.K. Hyattsville, Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1983</b>	REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stella L. Magnus				2a. DATE OF DEATH MONTH DAY YEAR Sept. 28 83		2b. HOUR 9:40pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 6 MONTH 12 DAY 24 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 59	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Montgomery		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Landry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Broussard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 031 14 1813		17. INFORMANT ADDRESS D. Keith Magnus, see # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5715 - Bleeding esophageal varices DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver - years DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1 Sept. 1983, to 25 Sept. 1983, that (I) saw the deceased alive on 25 Sept. 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)							
22b. SIGNATURE Horace W. Bernton, MD				22c. DATE SIGNED 9/29/83		22d. ADDRESS 4743 Bradley Blvd., Chevy Chase, Md. 20815	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 30, 1983		23c. NAME OF CEMETERY OR CREMATORY Cemetery Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				24b. ADDRESS Funeral Homes, P.A. Bethesda, Maryland		25. DATE RECD. BY REGISTRAR OCT 4 - 1983	

80% COTTON

CLIFTON





BP

DHMH - 16 SOM 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Properly completed and signed death certificates are required by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified at once.

Body received by Dr. Sankar H. Sankar

MEDICAL CERTIFICATION

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Arthur		H	Maillard	Jr	9-24-83					3:45 PM
3 SEX	Male		4. RACE	White		5 DATE OF BIRTH	MONTH		DAY	YEAR
							10-13-14			
6 AGE (IN YEARS LAST BIRTHDAY)	68		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	New York		7b. CITIZEN OF WHAT COUNTRY?	USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH
									WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Montgomery
10 CITY OR TOWN OF DEATH	Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		Pres. (Retired) Distillery	
13a. STATE	Maryland		13b. COUNTY	Montgomery		13c. CITY OR TOWN	Bethesda		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5225 Pooks Hill Road
14. FATHER'S NAME	Arthur		15. MOTHER'S MAIDEN NAME	Sadie		Goldberg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	WW II		17 INFORMANT	ADDRESS Gaithersburg, Md.			
						Dr. Robert Camps; 8 Thorburn Place				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUDDEN DEATH - VENTRICULAR FIBRILLATION</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION	N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	N/A		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		N/A				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		N/A				
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 24, 1983</u> to <u>SEPT. 24, 1983</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE	WILLIAM R. STERN		DEGREE	MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED			
							9-25-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	WILLIAM R. STERN		22e. ADDRESS	14816 PHYSICIANS LANE, ROCKVILLE, MD, 20850						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial		23b. DATE	9-26-1983		23c. NAME OF CEMETERY OR CREMATORY	King David Mem. Church, Falls Church, Virginia			
24. FUNERAL DIRECTOR NAME	Danzansky-Goldberg Chapels		24b. ADDRESS	1170 Rockville Pike, Rockville, Md.						

SEP 27 1983

At the end of the line

209 S. 1st St.  
St. Louis, Mo.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Ivan</b> MIDDLE <b>Malinowsky</b>		2a. DATE OF DEATH		MONTH <b>9</b> DAY <b>1</b> YEAR <b>83</b>		2b. HOUR <b>2:49 A.M.</b>	
3 SEX <b>M.</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>15</b> YEAR <b>-09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ukraine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NURSING HOME, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager-Safeway Stores</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Hyatts.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7401 New Hampshire Ave</b>	
14. FATHER'S NAME <b>Unobtainable</b>				15. MOTHER'S MAIDEN NAME <b>Unobtainable</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>204-26-1096</b>		17. INFORMANT <b>Sophia W. Malinowsky (Wife)</b>		ADDRESS <b>Same as 13E</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4349</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>recurrent - old cerebral infarct</b> (c) <b>arteriosclerosis generalized</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>3 years -</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

**Signure Syndrome, post cerebral infarct.**

19a. DATE OF OPERATION <b>NA.</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8.31</b> 19 <b>83</b> , to <b>9.1</b> 19 <b>83</b> , that (I) <del>was</del> lost saw the deceased alive on <b>8.31</b> 19 <b>83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>did</b> not view the body after death.							
22b. SIGNATURE <b>Federic W. Brennwald</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9.1.83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F.W. BRENNWALD</b>				22e. ADDRESS <b>831 University Blvd E. Springfield</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/3/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION <b>Suitland PG Maryland</b>	

24. FUNERAL DIRECTOR <b>Hines/Rinaldi 11800 N.H.Ave.S.S.Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canick</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

304-36-1086



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24904

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Charles Griffith Maloney</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Sept. 17-83</i>			2b. HOUR <i>0030 A</i>	
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 30, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> County MD.	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventest Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Farm Machinery</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Rockville</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>3 Orchard Way South (20854)</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Maloney</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Susan E. Hill</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>297-05-5270</i>		17. INFORMANT ADDRESS <i>Harold J. Maloney, same as #13</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Septicemia*

*5324*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Urinary tract infection*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

*Arteriosclerotic heart disease, Bleeding duodenal ulcer.*

19a. DATE OF OPERATION <i>8/31/83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding Duodenal Ulcer</i>		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9:17 1983</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>6001, Landan Rd, Chant, Md 20785</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/1/7</i> <i>1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>V. P. Chandar</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>9/17/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>V. P. Chandar</i>				22e. ADDRESS <i>6001, Landan Rd, Chant, Md 20785</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept. 19, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 22 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopopos. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
			FIRST MIDDLE LAST <b>YETTA MANSET</b>		9 27 83	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
FEMALE			WHITE		SEPTEMBER 22, 1917	
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
PENNSYLVANIA			U.S.A.		66 YRS	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
ROCKVILLE			SHADY GROVE ADVENTIST HOSP		MONTGOMERY COUNTY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS	
CLERK			U.S. GOVERNMENT		1040 WESTSIDE DRIVE 20878	
13b. MARYLAND			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MONTGOMERY			GAITHERSBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
SAMUEL LEVIN			BELLA BRUSILOVSKY		NO	
16b. SOCIAL SECURITY NO.			17. INFORMANT		16c. ADDRESS	
578-05-9051			ALEX MANSET, GAITHERSBURG, MARYLAND		1040 WESTSIDE DRIVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART 1. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>						
1629 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Disseminated parenchymat. pleural carcinoma</i> 2 MO.						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Lung Carcinoma (Large Cell)</i> 2 MO.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>chronic obstructive pulmonary disease</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>July 28</i> , 19 <i>83</i> , to <i>Sept. 27</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>Sept. 27</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Frank J. Mayo</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9-28-83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frank J. Mayo</i>		22e. ADDRESS <i>16220 Frederick Rd. #203 Gaithersburg, Md. 20877</i>				
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>9/30/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MOUNT LEBANON CEMETERY</i>		23d. LOCATION CITY OR TOWN <i>PRINCE GEORGE'S, MARYLAND</i>
24. FUNERAL HOME (NAME) <i>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 03 1983</i>		
232 CARROLL STREET, N. W., WASHINGTON, D. C.				25b. REGISTRAR'S SIGNATURE <i>Frank J. Mayo</i>		

Handwritten notes at the top of the page, including "RECEIVED" and "JAN 19 1964".

4772V

Main body of the document containing several lines of faint, mostly illegible text. Some words like "RECEIVED" and "JAN 19 1964" are visible in the upper left.

Handwritten notes in the middle section, including "RECEIVED" and "JAN 19 1964".

Bottom section of the document with faint text and a large, stylized handwritten mark or signature.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert - Marken</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>8</b> YEAR <b>83</b>		2b. HOUR <b>6:35 AM</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>13</b> YEAR <b>24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Belfast, No. Ireland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United Kingdom</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9239 Weatherlane Place</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Embassy</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>James</b> LAST <b>Marken</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Boyd</b> LAST <b>Boyd</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Patricia Marken</b> ADDRESS <b>9239 Weatherlane Pl Gaithersburg Md</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**  
**1539**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Metastatic Carcinoma - colon**  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**immed****6 yrs**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

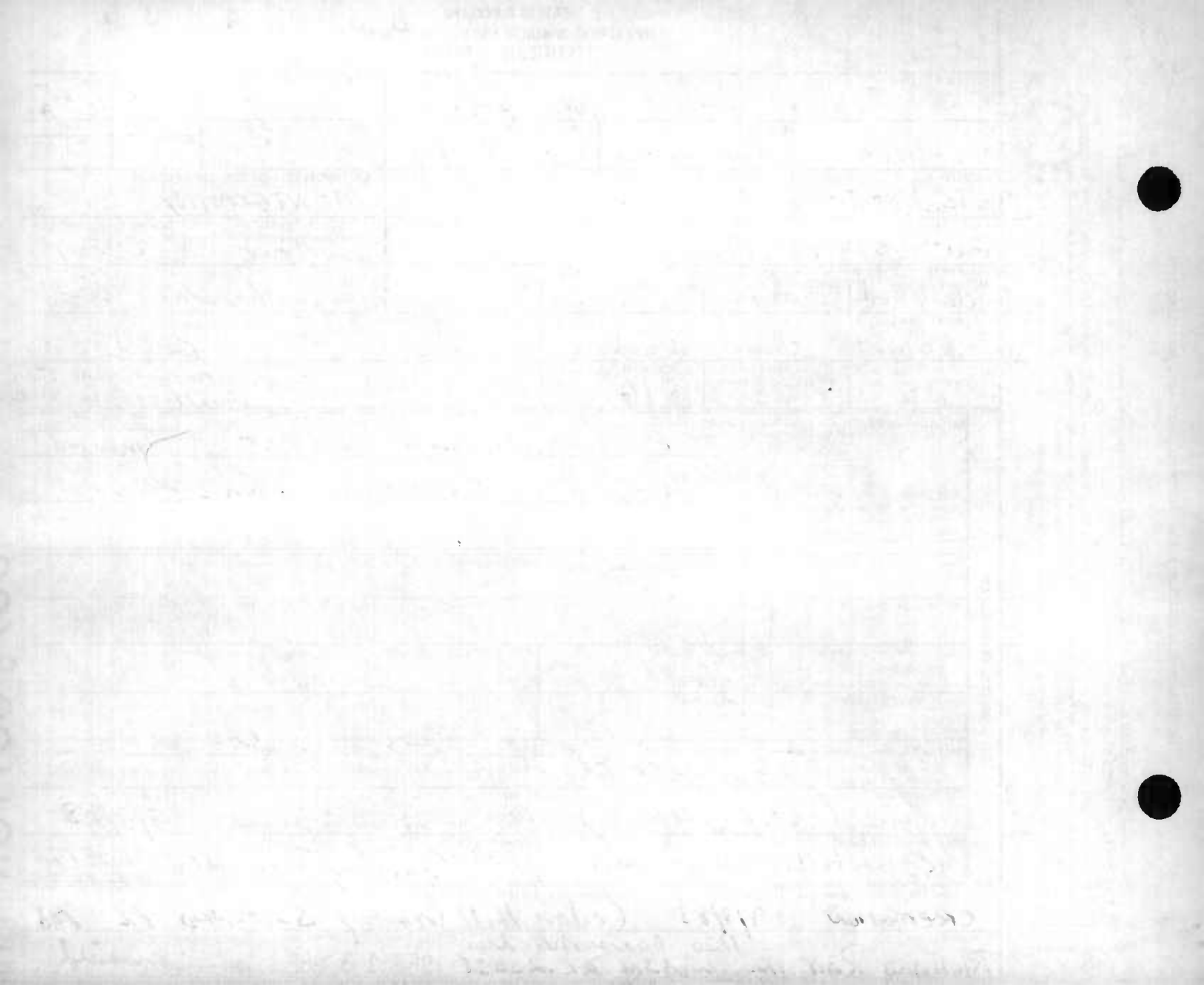
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>83</b> , to <b>September 8</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>September 8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Robert Millman, MD</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>9/8/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Millman, MD</b>		22e. ADDRESS <b>15100 Park Dr Gaithersburg Md 20877</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>9/8/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>SCOTLAND P.G. MD</b>
24. FUNERAL DIRECTOR NAME <b>RICHARD RAPP, INC</b>		25a. DATE RECD. BY REGISTRAR <b>SEP 13 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

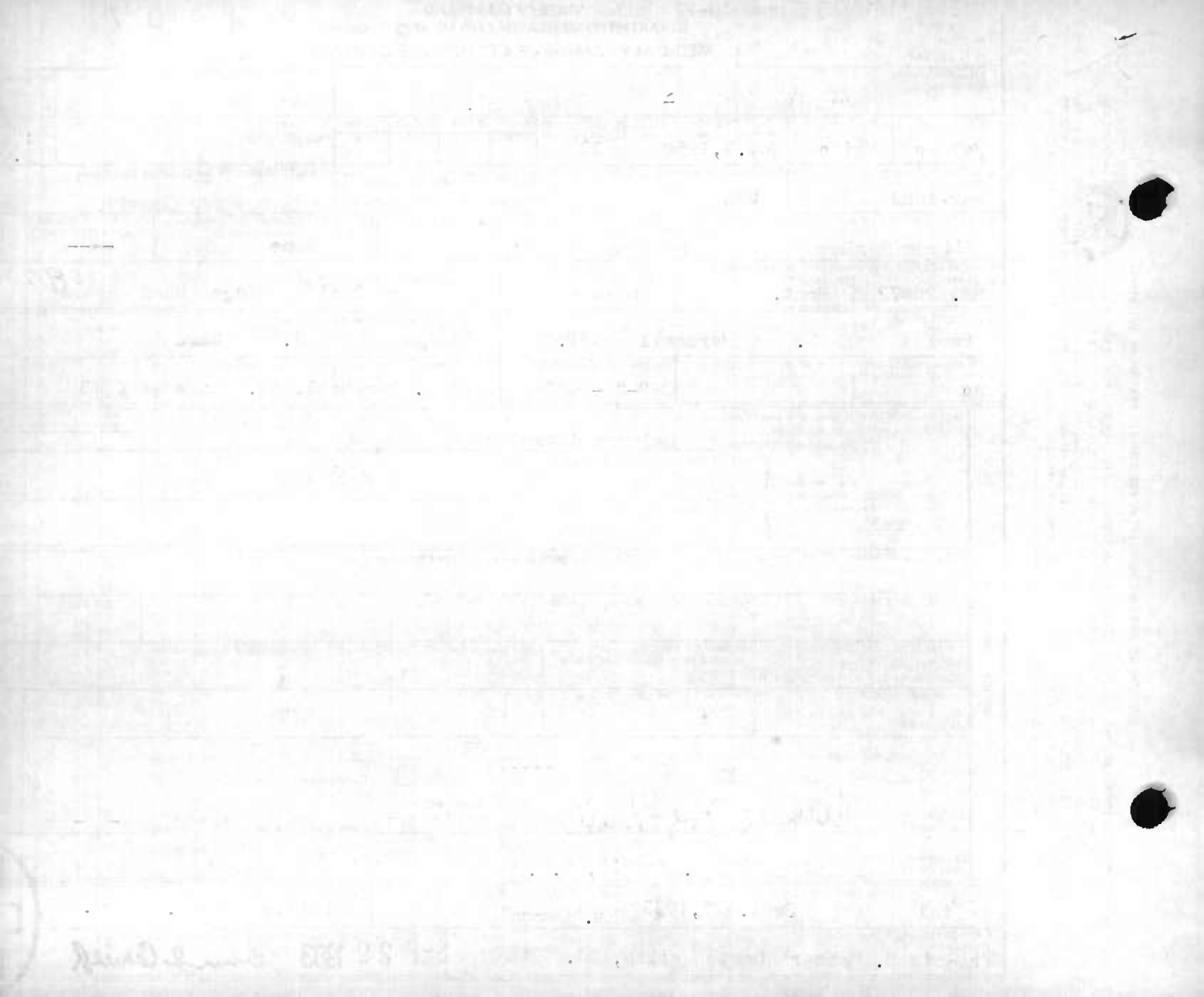




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS SUSPECTED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN IN YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 260

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24907			
1. DECEASED NAME (TYPE OR PRINT) <b>Juanita - Marshall</b>										2a. DATE KNOWN OF DEATH MONTH <b>9</b> DAY <b>23</b> YEAR <b>1983</b>		2b. HOUR M <b>5:52</b> P.M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Nov.</b> DAY <b>2</b> YEAR <b>1950</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>32</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD MONTH <b>9</b> DAY <b>23</b> YEAR <b>1983</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County,</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Damascus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>26811 Ridge Road</b>			
14. FATHER'S NAME FIRST <b>Paul</b> MIDDLE <b>E.</b> LAST <b>Marshall</b> SR. <b>Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Gladys</b> MIDDLE <b>J.</b> LAST <b>Ward</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>219-82-0683</b>		17. INFORMANT ADDRESS <b>Paul E. Marshall, Sr. Same as # 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Seizure disorder</b> <b>7803</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION <b></b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b></b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b></b>		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>							
22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from <b>Noturol causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>9-24-83</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Sept. 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		23d. LOCATION CITY OR TOWN <b>Sunshine</b> COUNTY <b>Mont.</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Francis H. Barber</b> ADDRESS <b>Laytonville, Md. 20879</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1983</b>							
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>													



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Filomena - Martinelli					9	4	83		540 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	Caucasian	JULY/13/06		77	MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NEW YORK	USA			Montgomery County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (#E))		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital				COOK		SCHOOL		
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
MARYLAND		MONTGOMERY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8 MARCIA CT. (20851)			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
(UNKNOWN)		CASCIA		(UNKNOWN)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		NONE		218-38-6947 JACK MARTINELLI (SON) SAME AS #13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Months

4140

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Hypertension, Rheumatoid Arthritis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/3 5/15 19 83, to 9/4 19 83, that (I) (we) lost  
saw the deceased alive on 8/3 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

9/4/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

CHAMBERS FUNERAL HOME RIVERDALE, MD.

SEP 4 1983 [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

February - 1950

Feb 10 - 1950

New York

Old Spring

March 10 - 1950

March 10 - 1950

March 10 - 1950

March 10 - 1950

March 10 - 1950

March 10 - 1950

March 10 - 1950

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March 10 - 1950

March 10 - 1950

March 10 - 1950

March 10 - 1950

March 10 - 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Thomas H. McCabe Jr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9-25-83</b>			2b. HOUR <b>8:45A.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 16 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CO. MD.</b>			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>V.P. Printing-Industries</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD 20852</b> 13b. COUNTY <b>MONT.</b> 13c. CITY OR TOWN <b>ROCKVILLE</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7109 OLD STAGE RD 20852</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS H MCCABE</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Brown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. <b>WW11 109-01-4170</b>		17. INFORMANT ADDRESS <b>Cathleen D. McCabe. Same as item 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CADIPX ARREST</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Pulmonary Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Ch. Tongue</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>1 1/2 yrs</b> <b>7 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>1476</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ch Tongue</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-21-1983</b> , to <b>9-25-1983</b> , that (I) (we) last saw the deceased alive on <b>9/25</b> , 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Edward T. O'Donnell MD</b>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/25/83</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward T. O'Donnell MD</b>					22e. ADDRESS <b>10313 Lough Ave. SS. Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/28/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Maryland.</b>		
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b> ADDRESS <b>5130 Wisc. Ave., N.W. Washington, D. C.</b>					25a. DATE REGD. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. O'Donnell</b>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William Thomas McGarrity</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Sept 28, 1983</i>			2b. HOUR <i>12 43 PM</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 7, 1916</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i>		7. IF UNDER 1 YEAR IF UNDER 2 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.				
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Realtor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Duffy Real Estate</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2010 Forestdale Road 20903</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Vincent McGarrity</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah Hanney</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW1</i>		17. INFORMANT ADDRESS <i>Rose A. McGarrity-wife- (same as 13e)</i>					

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cerebrovascular accident*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Aspiration Pneumonia*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Coronary Cardiac Failure*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

*Respiratory Insufficiency, Upper GI Bleeding*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/28/83</i> , 19 <i>83</i> , to <i>9/28/83</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>9/28/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Vivek C. Vaid</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/28/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Vivek C. Vaid M.D.</i>				22e. ADDRESS <i>7676 New Hampshire Ave Langley Park Md.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Oct. 1, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Montgomery Md.</i>	
24. FUNERAL DIRECTOR <i>Hines/Rinaldi Funeral Home</i>				1800 N.H. Ave., ADDRESS <i>Silver Spring, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 29 1983</i>	
				25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Judith Ann Mc Kee</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 13, 1983</b>		2b. HOUR <b>4:00a M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 24, 1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10216 Farnham Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Calvin Henry</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Mae Arrowsmith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT NAME ADDRESS <b>aid L. Roy Mc Kee (Husband) Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Disseminated Carcinomatosis</b> <b>1579</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cont of The Pancreas</b> (c) <b>Cont of The Pancreas</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>3 month</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5 Nov 83</b> 19 <b>83</b> , to <b>13 Sept 83</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>8/30</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Eugene P. Libe MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>13 Sept 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugene P. Libe MD</b>		22e. ADDRESS <b>10400 Connecticut Ave KEWINGSTON, Md. 20895</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 17, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alto Rest Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Altoon, Pennsylvania</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>				25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE <b>SEP 15 1983</b>			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										24912	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Edward H. McMahan</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>Sept 22 1983</b>		2b. MONTH DAY YEAR <b>12 19 83</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 17 26 57</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>Sept 22 1983</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co., MD.</b>			
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mont. General Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dept. of Highways</b>			
13a. STATE <b>MD</b>				13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward H. McMahan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kathleen Jenkins</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW II 246-32-6619</b>		17. INFORMANT ADDRESS <b>Sarah McMahan (sister) Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.A. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>				TITLE (SPECIFY) <b>1919 Seminary Road</b>				DATE SIGNED <b>Sept 22 1983</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>Silver Spring, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Sept. 25, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lewis Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Asheville, North Carolina</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Capitol Funeral Service, Falls Church, VA</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

BP \_\_\_\_\_

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Department of Health and Human Services

TABLE 1.

7

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Katharine L. McMinn				9/28/83		115 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		66 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash. D.C.		USA				Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				housewife		home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20906 11602 Joseph Mill Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Bertrand Hutchinson				Katharine Lappin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		718-10-7177		John D. McMinn same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>probable Brainstem Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus / Dental Carries</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 week</u> <u>3 1/2 week</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
Diabetes Mellitus / Dental Carries									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/28/83 to 9/28/83, that (I) (we) lost saw the deceased on 9/28/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)					
Frederick J. Barr		9/29/83		22e. ADDRESS					
				4500 College Ave. College Park, Md. 20740					
23a. BURIAL, CREMATION, REMOVAL (SP)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		10/3/83		Parklawn Memorial Park		Rockville, Maryland			
24. FUNERAL DIRECTOR (NAME)				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852				OCT 5 - 1983		John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

RECEIVED  
FEBRUARY 1964

MEMORANDUM  
TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24914

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR											
Maria		P.				Meagher		9/3		19		83				M											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR											
Female		Caucasian		September 29		77 YRS.						9/3		19		83 P. M.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH															
Maryland				United States								Montgomery County Maryland															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda				5114 Edgemoor Lane								Homemaker				Home											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								13a. STATE								13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
								Maryland				Montgomery				Bethesda				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				Bethesda, Maryland 20814			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST								FIRST MIDDLE LAST																			
Salvatore								Demarco								Anna Fitzpatrick											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.								17. INFORMANT											
No								213-42-7939								Richard Meagher Terrace Derwood, Maryland 20855											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1 DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) <u>Carcinoma of the lung.</u>																											
1629																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																											
(b) _____																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c) _____																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
None																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY?									
None																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
				P.M. 19				None																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																											
TITLE (SPECIFY)																											
Deputy																											
MEDICAL EXAMINER																											
DATE SIGNED 9/6/83																											
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.																											
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.																											
ADDRESS Silver Spring, Montgomery, Md.																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE															
Burial				September 7, 1983				Gate of Heaven Cemetery				Silver Spring, Maryland															
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey, Funeral Homes PA ADDRESS 7557 Wisconsin Ave Bethesda, Maryland 20814																											
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S NAME																											
SEP 9 1983																											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT STEPHEN MEDVE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT 16, 1983</b>		2b. HOUR <b>8:15 A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 14, 1935</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>14032 Cricket Lane</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chemical Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Calgon Corp.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>14032 Cricket Lane, 20904</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Medve</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Botzan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Judith C. Medve-wife-(same as 13e)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Small cell carcinoma of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>8 mos.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1982</b> , to <b>Sept 14, 1983</b> , that (I) (we) last saw the deceased alive on <b>9/11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Marc Rubin</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/16/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marc Rubin</b>		22e. ADDRESS <b>Naval Hospital, Bethesda, Md-MOB</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-19-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md.</b>
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home Silver Spring, Md.</b>		11800 N.H. Ave.,		25a. DATE REC'D. BY REGISTRAR <b>SEP 20 1983</b>	
				REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

Silver Spring Montessori, Md.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Sarah Miller</b>			2a DATE OF DEATH MONTH DAY YEAR <b>9/29/83</b>		2b HOUR <b>1 AM</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>APRIL 15, 1891</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.		
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF OTHER, GIVE ADDRESS) <b>ALTHEA WOODLAND NURSING HOME</b>		12a USUAL OCCUPATION (TYPE OF WORK OR WORK OF LIFE) <b>MERCHANT</b>	12b FURNITURE OR <b>STORE</b>	
13a STATE <b>MARYLAND</b>			13b COUNTY <b>MONTGOMERY</b>	13c CITY OR TOWN <b>SILVER SPRING</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOSHUA GELLER</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE JOBCO</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO. <b>391-32-8801</b>	17 INFORMANT <b>717 WHITAKER TERRACE, SILVER SPRING, MARYLAND</b>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **CORONARY ARTERIOSCLEROTIC VASCULAR DISEASE**

4292

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **GENERALIZED ARTERIOSCLEROSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**HYPERGLYCEMIA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>Oct 7, 1974</b> to <b>Sept 29, 1983</b> , that (we) last saw the deceased alive on <b>Sept 28, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <b>Bernard A. Fitzgerald M.D.</b>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <b>9-29-83</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD A. FITZGERALD</b>	22e ADDRESS <b>217 UNIVERSITY BLVD E, SILVER SPRING MD</b>		

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b DATE <b>10/2/1983</b>	23c NAME OF CEMETERY OR CREMATORY <b>BNAT ISRAEL CONGREGATION CEMETERY</b>	23d LOCATION CITY OR TOWN <b>PRINCE GEORGE'S, MD.</b>
24 FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>		25b DATE REC'D. BY REGISTRAR	
25a ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>		25b REGISTRAR'S SIGNATURE <b>OCT 6 1983</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Post mortem retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24917

1. FOR STATE REGISTRAR		2. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		9		8:10 PM	
MARY R. MESSINGER											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		White		11 04 07		75		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		U.S.A.				Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Wheaton		Randolph Hills NURSING HOME		Housewife		own home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		20903	
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8202 Tahona Drive			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
John		Phelen		Mary		Sullivan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
N/A		N/A		578-09-8975A		Henry S. Messinger-husband-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF									
5303		Aspiration									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Resophageal Stricture						Years	
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (if (this hospital) attended the deceased from above (b) (we) (did) (did not) view the body after death.		19 87 to 24 87		19 87		that (he) (we) lost					
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Michael Leibovich						30 87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Michael Leibovich		1120 N.H.A. St. Md 20904									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		10-3-1983		George Washington		Adelphi		Pr. Georges		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Hines/Rinaldi Funeral Home		1800 N.H. Ave. Silver Spring, Md.		OCT 4 - 1983		John J. Carls					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



White

New York

own name

Honolulu

1903

8202 Tabona Drive

Montgomery River Spring

Maryland

Sullivan

Mary

Phelan

John

Henry S. Neaseyger-husband-(name on 190)

W78-02-2272A

T/A

T/A

George Washington

10-3-1903

Serial

Haines/Edwards

11300 R.R. Ave  
Silver Spring, Md.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))

20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24918

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Spiro H Millios</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>Sept 13 1983</b>			2b. HOUR <b>8:30</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12-4-26</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <b>Sept 13 1983</b>	2d. HOUR <b>8:35</b>	
7a. BIRTHPLACE (STATE OR COUNTRY) <b>Albania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>		
10. CITY OR TOWN OF DEATH <b>Sil. Spg.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holt Cross Hosp</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurantier</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b> COUNTY <b>Mont</b> CITY OR TOWN <b>Sil Spg</b>		13b. INSIDE CITY LIMITS? <b>YES</b>		13c. STREET ADDRESS <b>208 Stirling Rd</b>		20901		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry S. Millios</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Querana Zotos</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>WW11</b>		17. INFORMANT ADDRESS <b>Cleo L. Millios-wife-(same as 13e)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Disease</b> 4 yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>								
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>Medical Examiner</b>				DATE SIGNED <b>Sept 14 1983</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>		ADDRESS <b>1949 Seminary Road, S.S. Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-16-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION <b>Silver Spring Montg.</b> STATE <b>Md.</b>		
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>		11800 N.H. Ave. <b>Sil. Spr. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>		

Alabama

Restaurant, Nat. Restaurant  
20901

Michigan

Texas

Florida

Illinois

2.

Harry

Clare J. Million-wife (name as 1930)

277-28-7873

WILL

yes

1919 Kentucky Road, S.E. 34.

John E. Rogers, INC.

Silver Spring, Md.

United States

1-1-1935

General

1110 S.W. Ave.  
S.W. 297. 41.

Minneapolis, Minnesota

43810110

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BR 216  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN FOREST MINNEMANN</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9-11-83</b>		2b. HOUR		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 5, 1954</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>9-11-83</b>	7d. HOUR		7e. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>125 Lee Ave. Apt. 4</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cabinet Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Wood work</b>			
13a. STATE <b>Md. 20901</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11215 Oak Leaf Dr. 20901</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Minniemann</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Billie Wise</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT ADDRESS <b>Billie Minnemann 5918 Beech Ave. 20817</b>				17b. ADDRESS <b>Beth., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9805 Narcotism</b> IMMEDIATE CAUSE (a) <b>Narcotism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 9/? 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>ingestion of Drugs</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Tokoma Pk., Md.</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Marggarita A. Korell</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>9-12-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Marggarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			
ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>											

JOSEPH GUNDEL'S - 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24920

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BARBARA JOAN MIZELLE			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 28 1983			2b. HOUR 11:04 p.m.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1953	6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 28 1983	7d. HOUR p.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Fenton V. Mizelle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine F. Fox			16. STREET ADDRESS 6 Brooks Ave. 20879		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 572-76-6004		17. INFORMANT ADDRESS Catherine F. Mizelle, 1966 Moreland Rd. Abington, Pa. 19001				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Multiple injuries</u> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <del>XXX</del> MONTH DAY YEAR 9:20 P.M. 9-28- 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 355 Montgomery Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>[Signature]</i>			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 9-29-83	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 3, 1983		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Prince George's, Md.		
24. FUNERAL DIRECTOR Orin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

007

4-1983

*[Signature]*

266

22 1,11. 23 24 25 26

Cost: \$1,200      [10/11/00]

John L. Johnson, Jr., President, J. L. Johnson & Co., Inc.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		83		24921	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK LUIGI MONALDO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 12 83</b>		2b. HOUR <b>9 55 PM</b>
3. SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SHOEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WM. HAHN CO.</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>800 HORTON DRIVE 20902</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH MONALDO</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-05-2549</b>		17. INFORMANT ADDRESS <b>JOSEPH A. MONALDO SAME AS 13 SON</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4275 Cardiac Arrest</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/12</b> 19 <b>83</b> to <b>present</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE <b>John J. Merendino</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN J. MERENDINO</b>		22e. ADDRESS <b>11620 KEMP MILL RD., SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>ENTOMBMENT</b>	23b. DATE <b>9/15/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Grier</b>	
25c. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



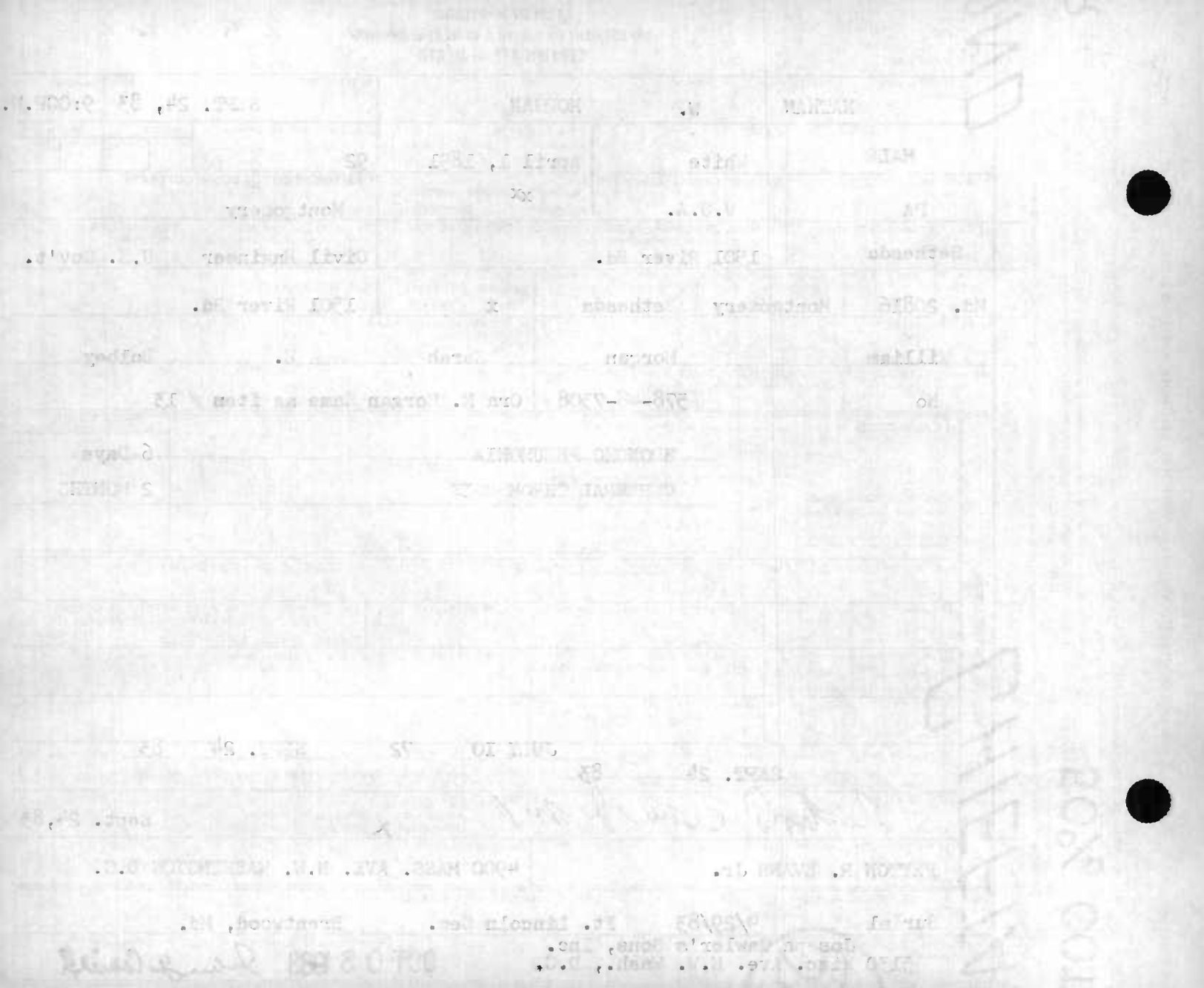
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 24922							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NATHAN W. MORGAN</b>						7a. DATE OF DEATH MONTH DAY YEAR <b>SEPT. 24, 83</b>		7b. HOUR <b>9:00 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 1, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1501 River Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1501 River Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Morgan</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah E. Dolbey</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-48-7308</b>		17. INFORMANT <b>Ora M. Morgan Same as item # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Days</b> <b>2 MONTHS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 10, 19 72</b> , to <b>SEPT. 24, 19 83</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 24, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Peyton R. Evans Jr.</i> DEGREE								22c. DATE SIGNED <b>Sept. 24, 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PEYTON R. EVANS Jr.</b>				22e. ADDRESS <b>4900 MASS. AVE. N.W. WASHINGTON D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/29/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 03 1983</b>					
25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>									



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Adolph</u> <u>Frankfort</u> <u>Morris</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>9-26-83</u>		2b. HOUR <u>9:55 P.M.</u>		
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>April 22, 1895</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington, DC</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Gaithersburg</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Wilson Health Care Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Power Dispatcher</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>PEPCO</u>	
13a. STATE <u>Maryland</u>				13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Gaithersburg</u>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <u>407 Russell Av., zip 20877</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>James</u> <u>Frankfort</u> <u>Morris</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lovisa</u> <u>Lindquist</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WW1</u>		17. INFORMANT ADDRESS <u>Hilma M. Morris (sister) same as #13</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary Edema.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Upper Gastrointestinal bleeding

DUE TO, OR AS A CONSEQUENCE OF

(c)

Primary - Colon. METASTATIC ADENOCARCINOMA LIVERPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Aortic Stenosis, Ischemic Heart Disease, Esophageal Stricture

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>4977 BATTERY LANE</u> <u>Bethesda</u> <u>MD</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>77</u> , to <u>9-26</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Roland Imperiel MD</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>9-27-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROLAND IMPERIEL</u>				22e. ADDRESS <u>4977 BATTERY LANE Bethesda MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Sept 30,</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION <u>Arlington</u> <u>Virginia</u> STATE	
24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey</u>				25. DATE REC'D. BY REGISTRAR <u>SEP 30 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	
ADDRESS <u>P.A. Rockville, Maryland</u>							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John J Morrison			2a. DATE OF DEATH MONTH DAY YEAR 9 22 83			2b. HOUR 1245 PM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Apr. 10, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.			
10. CITY OR TOWN OF DEATH Gaithersburg, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Rep.		12b. KIND OF BUSINESS OR INDUSTRY Automotive	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 19 Dunkirk Road 21212	
14. FATHER'S NAME FIRST MIDDLE LAST John Morrison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Walters					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 069 01 2070		17. INFORMANT ADDRESS Mr. John W. Morrison 43 Murray Hill Circle			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF, (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF, (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate lay standing	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  
Pneumonia / coronary artery disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that (I) (this hospital) attended the deceased from Sept 10, 19 83, to Sept 22, 19 83, that (I) (we) last saw the deceased alive on Sept 21, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Paul Krefling		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-28-83	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Krefling		22e. ADDRESS 1109 Spring St Silver Spring Md 20910					
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/26/83		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
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24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR SEP 28 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lois Mae Moore</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 17, 1983</b>			2b. HOUR <b>2:30 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 14 1928</b>		6. AGE [IN YEARS LAST BIRTHDAY] <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2721 Plyers Mill Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2721 Plyers Mill Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fred nm Miller</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helga nm Walker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Warren Moore</b> <b>2721 Plyers Mill Rd</b> <b>Silver Spring Md 20902</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY arrest</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>HEPATIC FAILURE - Metastatic disease</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>CARCINOMA OF COLON</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>6 weeks</b> <b>10 MONTHS</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
**NONE**

19a. DATE OF OPERATION <b>12.3.1982</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF COLON</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>December 1st</b> 19 <b>82</b> to <b>September 17</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>September 14</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Luis BENTOLILA MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Sept 17, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LUIS BENTOLILA</b>				22e. ADDRESS <b>5480 Wisconsin Ave</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9-19-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Prince Geo., Md.</b>	
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24. FUNERAL DIRECTOR <b>W. W. Chambers Co, Inc 8655 Georgia Ave</b> <b>Silver Spring, Md. 20910</b>		25a. DATE REC'D BY REGISTRAR <b>SEP 21 1983</b>		REGISTRAR'S SIGNATURE <b>John J. Carter</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Printed by  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>Thomas ADEN Murphy</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>9-30-83</u>				
3. SEX <u>Male</u>					2b. HOUR <u>5:24 A.M.</u>				
4. RACE <u>CAUCASIAN</u>					5. DATE OF BIRTH MONTH DAY YEAR <u>10 21 06</u>				
6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.					7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>TRELAND</u>					7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.				
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>GAS STATION OWNER</u>					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <u>MARYLAND</u>					13b. COUNTY <u>MONTGOMERY</u>				
13c. CITY OR TOWN <u>SILVER SPRING</u>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS <u>14801 FLINTSTONE LANE</u>					20904				
14. FATHER'S NAME FIRST MIDDLE LAST <u>PATRICK</u> <u>MURPHY</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MARGARET</u> <u>O'BRIEN</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>					16b. SOCIAL SECURITY NO. <u>579-07-9127</u>				
17. INFORMANT ADDRESS <u>ELLEN B. MURPHY WIFE SAME AS 13</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Heart Disease</u> <u>old stroke</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY</u> 19 <u>76</u> , to <u>SEPTEMBER 29</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>SEPTEMBER 29</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>					22c. DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BLAINE H. ETG</u>					22e. ADDRESS <u>9801 Georgetown School Spring Md 20902</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>					23b. DATE <u>OCT. 3, 1983</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>					23d. LOCATION CITY OR TOWN COUNTY STATE <u>SILVER SPRING MONT MD</u>				
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> ADDRESS <u>500 UNIVERSITY BLVD., W. SILVER SPRING, MD.</u>					25. DATE RECD. BY REGISTRAR <u>6</u> 1983 REGISTRAR'S SIGNATURE <u>[Signature]</u>				

BP \_\_\_\_\_

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Handwritten text in the middle section of the page, appearing to be a list or a series of notes, with some words like "and" and "the" visible.

Handwritten text at the bottom of the page, including a signature and a date, with some words like "and" and "the" visible.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LAWRENCE HORTON MURPHY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 19 1983</b>		2b. HOUR <b>6:03 a.m.</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DECEMBER 28 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.M.C.</b>
13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>FAIRFAX</b>	13c. CITY OR TOWN <b>VIENNA</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUDLEY STOWE MURPHY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LULA LONG</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1939-1959 236-07-8009</b>		17. INFORMANT ADDRESS <b>FRANKIE P. MURPHY, 7915 MADRON LANE, VIENNA, VA</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **PNEUMONIA**

1629

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **SQUAMOUS CELL CARCINOMA OF THE LUNG**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **SEPTEMBER 18 1983**, to **SEPTEMBER 19 1983**, that (I) (we) last  
saw the deceased alive on **SEPTEMBER 19 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>RK Ferguson</b>	DEGREE <b>LT, MC USNR</b>	22c. DATE SIGNED <b>20 Sept 83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. K. FERGUSON, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>

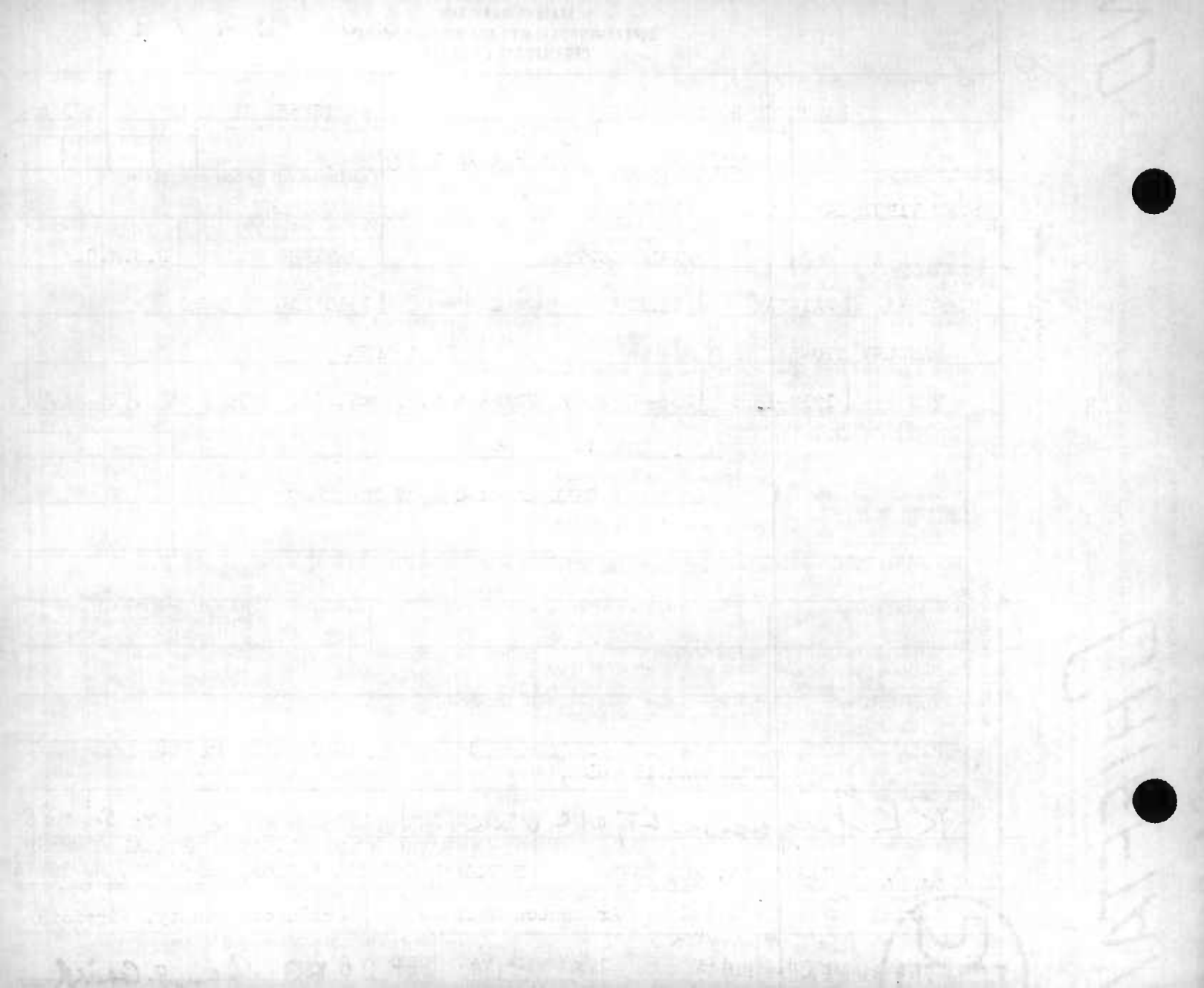
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9/23/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington County, Virginia</b>
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24. FUNERAL DIRECTOR NAME <b>Murphy FUNERAL HOME</b>	ADDRESS <b>Falls Church, VA.</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>	25b. REGISTRAR'S SIGNATURE <b>Sam J. Carver</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of place.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					2. REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM JOHN MURRAY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9-1-83</b> 2b. HOUR <b>7:00 A.M.</b>				
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 26, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>WHEATON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3811 KAYSON STREET</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>C.P.A.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GEORGETOWN UNIV. HOSP.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>MARYLAND MONTGOMERY WHEATON</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3811 KAYSON STREET, 20906</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM JAMES MURRAY</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOHANNA McNULTY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>199-03-5451</b>		17. INFORMANT <b>RETA S. MURRAY</b>		ADDRESS <b>SAME AS 13 WIFE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5715</b> IMMEDIATE CAUSE (a) <b>Massive hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Liver failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Chronic cirrhosis of liver</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>2 yrs.</b> <b>10 yrs.</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Severe electrolyte imbalance</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 8/19</b> , 19 <b>83</b> , to <b>9/1</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>8/19</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Richard P. Delaney, M.D.</b>					22c. DATE SIGNED <b>9/1/1983</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard P. Delaney, M.D.</b>		
22e. ADDRESS <b>4323 Havard Street, Silver Spring, Md. 20906</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/3/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>			
24. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b> NAME ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		

 Springer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

BP

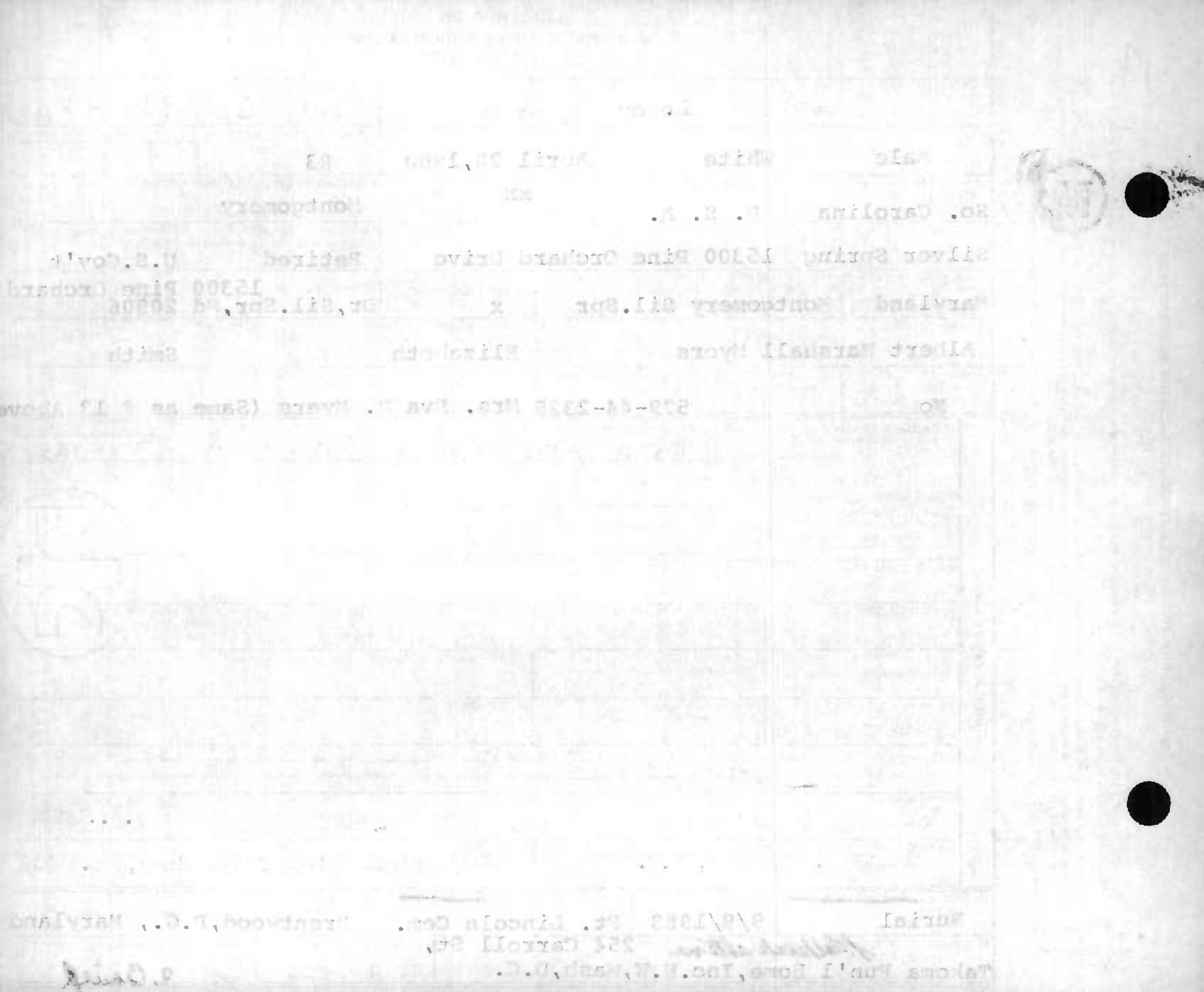
DHMM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dwight LeRoy Myers			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 6, 1983		2b. HOUR 9:20 A.M.						
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 28, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) So. Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15300 Pine Orchard Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15300 Pine Orchard Dr, Sil. Spr, Md 20906		
14. FATHER'S NAME FIRST MIDDLE LAST Albert Marshall Myers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-44-2325		17. INFORMANT ADDRESS Mrs. Eva M. Myers (Same as # 13 Above)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 METASTATIC COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 1980, to SEPT. 6, 1983, that (I) (we) last saw the deceased alive on Aug. 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.											
22b. SIGNATURE Eugene P. Flannery M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9.6..1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY, M.D.						22e. ADDRESS 18111 Prince Philip Drive Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/9/1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland			
24. FUNERAL DIRECTOR NAME Takoma Fun'l Home, Inc. N.W., Wash, D.C.						24a. ADDRESS 254 Carroll St		24b. DATE REC'D. BY REGISTRAR SEP 8 1983		24c. REGISTRAR'S SIGNATURE J. C. C. C.	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 4 9 3 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

I. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Samuel

Edward

Myers

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 9/8 19 83 2b. HOUR M 8:54 A. M

3. SEX  
Male

4. RACE  
White

5. DATE OF BIRTH  
MONTH DAY YEAR Jul. 7, 1915

6. AGE (IN YEARS)  
LAST BIRTHDAY 68 YRS

IF UNDER 1 YR.  
MONTHS DAYS HOURS MIN

IF UNDER 24 HRS.  
HOURS MIN

7c. DATE PRONOUNCED DEAD 9/8 19 83 2d. HOUR M 8:54 A. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?  
United States

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Montgomery County MD.

10. CITY OR TOWN OF DEATH  
Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
10805 Wheeler Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Insurance Agent 12b. KIND OF BUSINESS OR INDUSTRY  
United Ins.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland

13b. CITY  
Montgomery

13c. CITY OR TOWN  
Silver Spring

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

13e. STREET ADDRESS  
10805 Wheeler Drive 20901

14. FATHER'S NAME  
FIRST Myer

MIDDLE Isaac

LAST Myers

15. MOTHER'S MAIDEN NAME  
FIRST Rachel

MIDDLE Brett

LAST Brett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN) Yes

(IF YES, GIVE WAR OR DATES)  
WW II

16b. SOCIAL SECURITY NO.  
171 07 4381

17. INFORMANT ADDRESS  
Wife: Sophia Myers same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute myocardial disease

4291

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Chronic leukemia.

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

None

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED 9/8/83

EXAMINER'S NAME  
(TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

1919 Seminary Road  
Silver Spring, Montgomery, Md.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) Burial

23b. DATE

Sept. 11, 1983 Judean Gardens

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION  
CITY OR TOWN

Olney, Maryland

COUNTY

STATE

24. FUNERAL DIRECTOR NAME

Ives-Pearson Funeral Home

ADDRESS

Falls Church, Va. 22046

25a. DATE REC'D. BY REGISTRAR

SEP 13 1983

25b. REGISTRAR'S SIGNATURE

R. J. Carver

83

100

100

100

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 4 9 3 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
James Robert Neely			September 18 1983			3 <sup>30</sup> A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Caucasian	May 30 1919	64 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.	U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park	Washington Adventist Hospital			Restaurant Owner				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Montgomery			Silver Spring		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES?		
Joseph Neely			Lepha Coons			(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
17. INFORMANT			18. SOCIAL SECURITY NO.			19. ADDRESS		
Barbara Ellen Neely			578-01-7999			Wife Same as 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY ARREST

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

HOURS

1629

DUE TO, OR AS A CONSEQUENCE OF

(b) PNEUMONITIS 2° C

DUE TO, OR AS A CONSEQUENCE OF

(c) BRONCHOGENIC CARCINOMA MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/17 to 9/18, 1983, that (I) (we) last saw the deceased alive on 8/17, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

Kenneth Cruze MD

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR  
NAME

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

500 University Blvd., W. Silver Spring, Md.

SEP 22 1983

John J. Conner

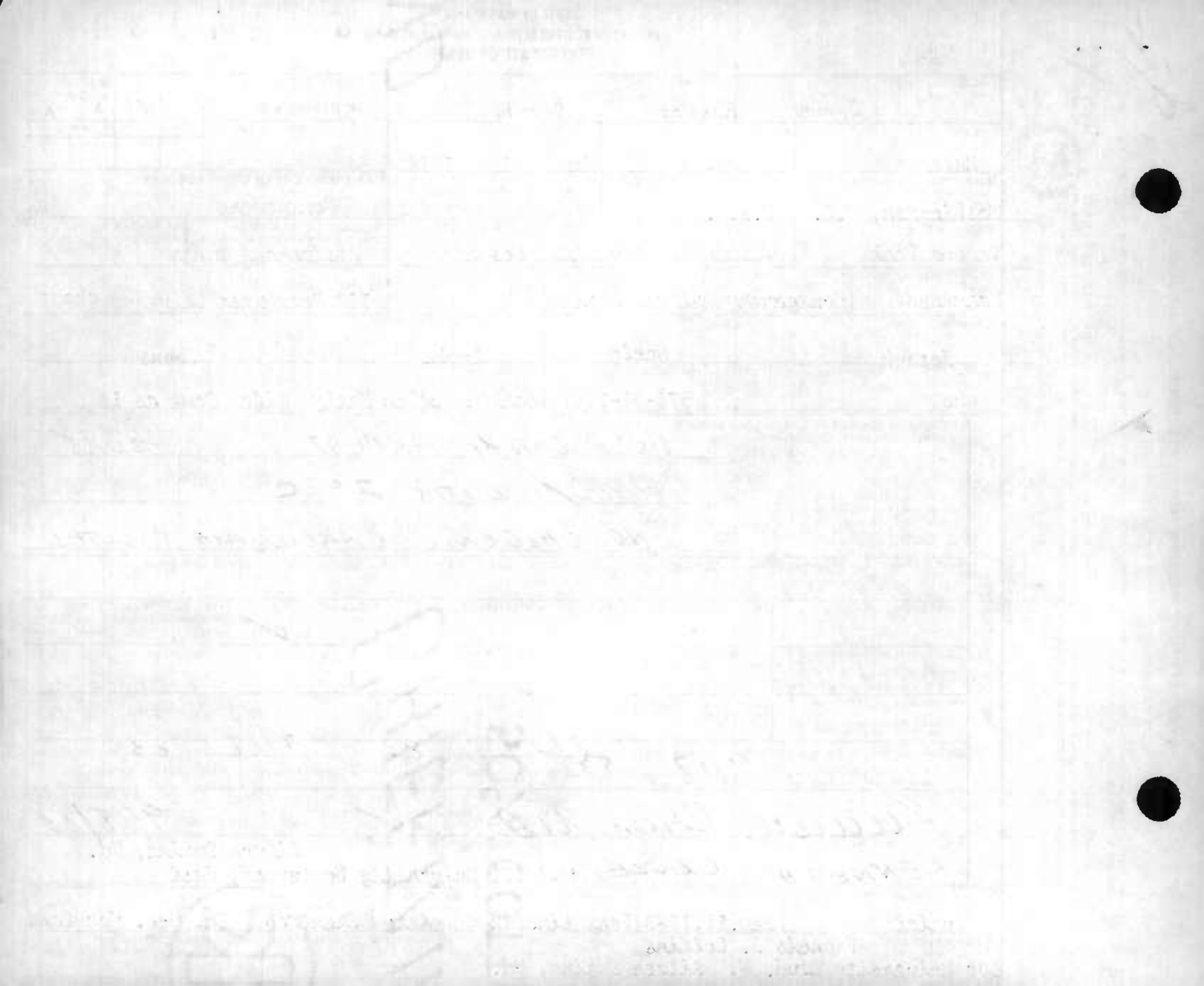
BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or medical investigator should be notified and advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CLAY THIDEOS NEUHAUS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 21 1983</b>			
3. SEX <b>MALE</b>				2b. HOUR <b>8:30 PM</b>			
4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 4 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.N.</b>					
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>PASSADENA</b>		13c. STREET ADDRESS <b>1304 McNABBS LANE 21122</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>458-40-4753</b>		17. INFORMANT ADDRESS <b>RUBY W. NEUHAUS 1304 McNABBS LANE PASSADENA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE AND RENAL FAILURE</b> <b>8199</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASPIRATION PNEUMONIA</b> (c) <b>MOTOR VEHICLE ACCIDENT</b> <b>WITH CERVICAL SPINE DISLOCATION</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MD</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION <b>23 AUG 1983</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CERVICAL SPINE DISLOCATION</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>AUG 17 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) <b>MOTOR VEHICLE ACCIDENT</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 17 1983</b> , to <b>SEPTEMBER 21 1983</b> , that (I) (we) lost saw the deceased alive on <b>SEPTEMBER 21 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R. L. Sollock</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>23 SEP 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. L. SOLLOCK, LCDR, MC, USNR</b>				22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-26-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOW RIDGE M.F.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DORSEY HOWARD MD</b>	
24. FUNERAL DIRECTOR NAME <b>McCULLY F.A. 3204 MOUNTAIN RD</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HILDA V. NIEMEYER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>09 13 83</b>					2b. HOUR <b>2204</b> M	
3. SEX <b>female</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 31, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Practical Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>			
13a. STATE <b>District of Col.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4307 Harrison St. N.W.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles E. Grimes</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie A. Rentzell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		(IF YES, GIVE WAR OR DATES) <b>---</b>		16b. SOCIAL SECURITY NO. <b>578-24-9354</b>		17. INFORMANT ADDRESS <b>Rev. Richard Reichard 9701 Veirs Dr. Rockville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4140 CONGESTIVE HEART FAILURE</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 3, 1983</b> to <b>Sept 13, 1983</b> , that (I) (we) lost saw the deceased alive on <b>23 Sept 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thomas E. Dooley, MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/24/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas E. Dooley, M.D.</b>						22e. ADDRESS <b>2901 Olney-Sandy Springs Rd. Olney, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Sept. 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Va.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>The Hysong Company 1300 N St. N.W. Washington, D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>4 1983</b>					

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UNITED STATES DEPARTMENT OF THE INTERIOR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24935

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Barbara E O'Brien</b>						2a. DATE KNOWN OF DEATH <b>9 9 1983</b>		2b. HOUR <b>11:45 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>20</b> YEAR <b>08</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>75</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	7c. DATE PRONOUNCED DEAD <b>9 9 1983</b>		7d. HOUR <b>11:45 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10250 Westlake Dr. #901</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10250 WESTLAKE DR</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Hinkson</b> LAST <b>Edwar ds</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ma rgaret</b> MIDDLE <b></b> LAST <b>Johnson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-44-9103</b>		17. INFORMANT <b>Pauline Williams, 3900 Connecticut Ave, NW Washington, DC 20008</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR DIS.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>YVS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>-</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>AM-P.M. 9 9 1983</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>AM-P.M. 9 9 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>DIED IN BED</b>					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>HOME</b>		21f. LOCATION STREET <b>10250 WESTLAKE DR</b> CITY OR TOWN <b>BETHESDA</b> COUNTY <b>MONT</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Francis C. Mayle</i>		TITLE (SPECIFY) <b>Dept</b>		M.D. <b></b>		MEDICAL EXAMINER <b></b>		DATE SIGNED <b>9/9/83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C. Mayle M.D.</b>		ADDRESS <b>8200 Wisconsin Ave. Bethesda, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN <b>Suitland, Maryland</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Jos. Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisconsin Ave., N.W., Washington, DC</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 16 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JACOB WILLIAM NIGG</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 23 1983</b>		2b. HOUR <b>11:30am</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 19 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PANAMA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.M.C.</b>	
13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>FAIRFAX</b>		13c. CITY OR TOWN <b>FAIRFAX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>5050 DEQUINCEY DRIVE</b>		13f. CITY OR TOWN <b>FAIRFAX</b>		13g. STATE <b>VA</b>		13h. ZIP CODE <b>22032</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALOIS NIGG</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ALGUNDA SCHNEIDER</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES 1927- 1953</b>		16b. SOCIAL SECURITY NO. <b>577-48-7867</b>	
17. INFORMANT <b>JACQUELINE E. MANVELL</b>		17a. ADDRESS <b>5050 DEQUINCEY DRIVE</b>		17b. CITY OR TOWN <b>FAIRFAX</b>		17c. STATE <b>VA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4332 IMMEDIATE CAUSE (a) RIGHT VERTEBRAL ARTERY THROMBOSIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>14 SEPTEMBER 19 83</b> to <b>23 SEPTEMBER 19 83</b> , that (I) (we) last saw the deceased alive on <b>23 SEPTEMBER 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard P. Erwin</i>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>23 SEPTEMBER 1983</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. P. ERWIN LT. MC USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA MD 20814</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>Money &amp; King Vienna Fun'l Hm.,</b>		ADDRESS <b>Vienna, Va. 22180</b>		DATE RECEIVED BY REGISTRAR <b>OCT 03 1983</b>			

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WASHINGTON

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WASHINGTON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY ADESSE OED</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 14 83</b>		2b. HOUR <b>3<sup>30</sup> PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 31 05</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Takoma Park MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Adventist Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Takoma Park Montgomery MD</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Lefebvre</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Carmier</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218 56 9065</b>		17. INFORMANT ADDRESS <b>Mary O. Weaver Derwood, Maryland 20855</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4039 Acute &amp; chronic renal failure</b> IMMEDIATE CAUSE (a) <b>Acute &amp; chronic renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe nephrosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> Approximate interval between onset and death: <b>Weeks</b> <b>Years</b> <b>Years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Severe atherosclerotic heart disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/10/83</b> 19 <b>83</b> , to <b>9/14</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/13</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Samuel J. Scott, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/15/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMUEL J. SCOTT</b>		22e. ADDRESS <b>5632 SHILOH DRIVE, BOLLING, MD. 20846</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-16-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem., Arlington</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Virginia</b>					
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John L. Smith</b>	
1331 Rockville Pike Rockville, Maryland 20852					

Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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A.2.4.2.

9

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jean Marley O'Leary			2a. DATE OF DEATH MONTH DAY YEAR September 2, 1983			2b. HOUR 3:00A.M.					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8711 Cranbrook Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian/Atomic Commission		12b. KIND OF BUSINESS OR INDUSTRY Energy			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8711 Cranbrook Court		
14. FATHER'S NAME FIRST MIDDLE LAST William Marley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Dillon			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO 068-05-6438	
17. INFORMANT John M. Watson, Son-in-law			17. ADDRESS Same as item #13								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Respiratory Failure7991  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

24 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>6/2</u> , 19 <u>83</u> , to <u>9/1</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							

22b. SIGNATURE J.S. Macdonald		DEGREE M.D.		22c. DATE SIGNED 9/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.S. Macdonald, M.D.		22e. ADDRESS 5401 Western Avenue, N.W. Washington, D.C. 20015			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 2, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 8 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 5 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST CARROLL WILLIAM OLIFF		MONTH DAY YEAR SEPTEMBER 9 1983	
3. SEX MALE		2b. HOUR 10:20a M	
4. RACE CAUCASIAN		6. AGE (IN YEARS LAST BIRTHDAY)	
5. DATE OF BIRTH MONTH DAY YEAR JULY 19 1915		68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
13b. COUNTY ARLINGTON		12c. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE	
13c. CITY OR TOWN ARLINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN CARROLL OLIFF		13e. STREET ADDRESS 5550 COLUMBIA PIKE 99999	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUGENIA IONE DODD		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	
16b. SOCIAL SECURITY NO. 1943-1968		17. INFORMANT ADDRESS MILDRED OLIFF, 5550 COLUMBIA PIKE, ARLINGTON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1629</u> METASTATIC ADENOCARCINOMA OF THE LUNG WITH SEVERE DUE TO, OR AS A CONSEQUENCE OF BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED 12 SEP 83	
22b. SIGNATURE L. Hall, LT, MC, USNR		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. HALL, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9-13-83	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA.	
24. FUNERAL DIRECTOR IVES-PEARSON FUNERAL HOMES		25a. DATE REC'D. BY REGISTRAR SEP 15 1983	
ADDRESS 2847 WILSON BLVD ARL, VA		25b. REGISTRAR'S SIGNATURE John J. Carver	



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UNITED STATES  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

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APPROVED AND FORWARDED:  
[illegible]  
SPECIAL AGENT IN CHARGE

UNITED STATES  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ANNA OLIPHANT</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>12</b> YEAR <b>83</b>		2b. HOUR <b>6:45 P.M.</b>	
3 SEX <b>F</b>	4 RACE <b>C I</b>	5. DATE OF BIRTH MONTH <b>6</b> DAY <b>25</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MINNESOTA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONT GOMERY</b> MD.
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FERNWOOD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY —
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>CALIFORNIA</b> 13c. COUNTY <b>SAN DIEGO</b> 13d. CITY OR TOWN <b>LA JOLLA</b>			13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <b>5426 Dolphin Pl. 99999</b>	
14. FATHER'S NAME FIRST <b>Lars</b> MIDDLE <b>LARS</b> LAST <b>SELVAAG</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Christina</b> MIDDLE <b>Jacobsen</b> LAST <b>?</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>112-20-0812</b>		17. INFORMANT <b>1077 30th St. N.W. APT 412 WASH. D.C. 20007</b>		
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Pleoma Brain</b> <b>1919</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____						
19a. DATE OF OPERATION <b>8/19/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Biopsy Brain tumor</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <b>19</b> MONTH <b>9</b> DAY <b>12</b> YEAR <b>83</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>9/9</b> CITY OR TOWN <b>83</b> COUNTY <b>9/12</b> STATE <b>83</b>		
22a. I certify that (1) (the hospital) attended the deceased from <b>9/12</b> 19 <b>83</b> to <b>9/12</b> 19 <b>83</b> , that (1) (the) last opinion death occurred on the date and hour and from the causes stated above. (2) (the) (view the body after death).						
22b. SIGNATURE <b>Blaine Fitzgerald</b>				22c. DATE SIGNED <b>9/12/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Blaine Fitzgerald</b>				22e. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (PREPARE) <b>Removal-Donation</b>		23b. DATE <b>9-12-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Uniform Services Univ. Bethesda Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Carol Hynes</b> ADDRESS <b>Capitol Funeral Service-7211 Lee Highway-Falls Church, Va.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b> REGISTRAR'S SIGNATURE <b>John J. Conner</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

#1, Film 584 10/14/83 kam				STATE OF MARYLAND				24940			
FOR 12a 1- STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
RANANLAL + M. PARIKH				SEPTEMBER 2, 1983				6:00 PM			
3. SEX MALE		4. RACE INDIAN		5. DATE OF BIRTH FEBRUARY 5, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIA		7b. CITIZEN OF WHAT COUNTRY? INDIA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5000 ADRIAN STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY INDIA GOVT.			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5000 ADRIAN STREET 30853			
14. FATHER'S NAME FIRST MANKLAL MIDDLE PARIKH LAST				15. MOTHER'S MAIDEN NAME FIRST DIWALIBEN MIDDLE PARIKH LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-88-0525		17. INFORMANT ARVIND PARIKH, SON, 5000 ADRIAN ST., ROCKVILLE				ADDRESS MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 DEHYDRATION RESP. FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) STROKE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC VASC. DISEASE.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS.											
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from MAY 19 80, to SEPTEMBER 2 19 83, that (I) (we) lost saw the deceased alive on AUG 21 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE K. Deshpande				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-2-83	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) K. DESHPANDE M.D.				22f. ADDRESS 6001 LUX LANE, ROCKVILLE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATORY		23b. DATE 9/3/83		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY				23d. LOCATION CITY OR TOWN COUNTY PG. STATE SUITLAND PG. MD.			
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. 1120 CONN. AVE., N.W. #940, WASH., D.C. 20036				25a. DATE REC'D. BY REGISTRAR SEP 8 1983		25b. REGISTRAR'S SIGNATURE [Signature]					

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CHIT CHINA

PC&C COLLOIDAL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANN A DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 9/14/83			2b. HOUR 6:16 AM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 24 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY C & P TELEPHONE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MARYLAND MONTGOMERY WHEATON			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 2923 PARKER AVENUE 20902				
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM M. CREEL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA MOUNTJOY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-22-7976		17. INFORMANT CHRIS J. PERRUS		ADDRESS SAME AS 13 HUSBAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1509 IMMEDIATE CAUSE (a) <u>gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of Esophagus, Squamous 5mo.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/13/83</u> , 19____, to <u>9/13/83</u> , 19____, that (I) (we) lost saw the deceased alive on <u>9/13/83</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jeremy V. Cooke</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEREMY V. COOKE				22e. ADDRESS 10400 CORNW. AVE., KENSINGTON, MD. 20905					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/17/83		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION SILVER SPRING COUNTY MONT MD.			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR SEP 19 1983		25b. REGISTRAR'S SIGNATURE <u>James J. Collins</u>			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RAYMOND G. PETERNELL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>September 24, 1983</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 31, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist, Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electric Co.</b>	
13a. STATE <b>Florida</b>		13b. COUNTY <b>Hillsboro</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1605 Croister Drive 33570</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anton Peternell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Muth</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW 11 343 01 7981A</b>		17. INFORMANT ADDRESS <b>Thelma E. Peternell Same as #13 (Wife)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma - Hepatic Encephalopathy</b> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Anterior Wall MI, Hypertension, Cerebrovascular Accident</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> , 19 <b>83</b> , to <b>9/24</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Daniel Goldberg</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/24/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Goldberg</b>				22e. ADDRESS <b>10401 Old Georgetown Rd - Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>9/27/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	
24. ADDRESS <b>Hyattsville, Maryland</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 24943			
1. DECEASED NAME (TYPE OR PRINT) <b>Carl Henning Peterson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 29, 1983</b>				2b. HOUR PM <b>6:55 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 24, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>87</b>		IF UNDER 1 YEAR MONTHS DAYS <b>87</b>		IF UNDER 24 HRS HOURS MIN <b>6:55</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rockville Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Printer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>			
13a. STATE OF RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. CITY OR TOWN <b>Rockville</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>79 Winona Road, 20855 (01106)</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl Otto Peterson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna D. Blomdahl</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>327-10-2196</b>		17. INFORMANT ADDRESS <b>Mr. Norman C. Peterson, Son, 17732 Caddy Drive, Derwood, MD. 20855</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Years</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (we) attended the deceased from <b>March 15, 1981</b> , to <b>Sept. 29, 1983</b> , that (I) (we) lost saw the deceased alive on <b>Sept. 29, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (live) (did) (did not) view the body after death											
22b. SIGNATURE <b>Raymond T. Benack, MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>9/30/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raymond T. Benack, MD</b>				22e. ADDRESS <b>4115 Colie Drive., Wheaton, Maryland 20906</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal/Shipment</b>		23b. DATE <b>Oct. 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hills of Rest Cemetery Joliet, Illinois</b>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 5 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>					

10-13-1943

10-13-1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dagny R. Pettit</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 8, 1983</b>		2b. HOUR <b>6:40A</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 6, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON STATE</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>OLNEY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>15311 PINE ORCHARD DRIVE 20906</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>THEODORE RUDBACK</b>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AMANDA HOLM</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>500-50-6405</b>		17. INFORMANT ADDRESS <b>MANSON B. PETTIT, SAME AS 13. HUSBAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>9-7</b> 19 <b>83</b> to <b>9-8</b> 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>9-7</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9-8-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Alberto Rotsztain</b>		22e. ADDRESS <b>3701 Rossmoor Boulevard Silver Spring, Maryland 20906</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>9/10/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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200-20-4402

CHILLY MAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George S Pfaus</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 11 83</b>			2b. HOUR <b>8:25</b> M			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 - 15 - 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Tokoma Park, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10810 St. Paul Street 20895</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>August Pfaus</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Petronella Feitzinger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>135-16-3692</b>		17. INFORMANT ADDRESS <b>Mrs. Jacqueline R. Pfaus (Same as #13.)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>Sept 8, 1983</b> , to <b>Sept 11, 1983</b> , that (1) (we) lost <b>Sept 11, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we did (and) not view the body after death.									
22b. SIGNATURE <b>John Barr, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/11/83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Barr, MD</b>		22e. ADDRESS <b>10500 Summit Ave, Kensington, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>9/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <input checked="" type="checkbox"/>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25. DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>			
						REGISTRAR'S SIGNATURE <b>John J. Conick</b>			

BP \_\_\_\_\_



Ed. Gov't

Honorable County

New Jersey

Compliance Officer

20082

Refinement

Refinement

Plan

Refinement

Mrs. Jacqueline R. Pless (Form 20082)

132-10-3082

NO

Refinement

Refinement

Refinement

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JANE PHLEGAR</b>				MONTH DAY YEAR <b>9/24/83</b>		2b. HOUR <b>4:54 A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 1, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>62</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (STATE, COUNTY, CITY OR TOWN) <b>Wash., D.C.</b>		13b. CITY OR TOWN <b>Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>4740 Conn. Ave. N.W. # 806</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph W. Fulton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ione McDaniel</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>515-03-1604</b>		17. INFORMANT <b>Benjamin F. Phlegar/</b>		ADDRESS <b>Wash., D.C. 4740 Conn. Ave. N.W.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/25, 1983</b> , to <b>9/24, 1983</b> , that (I) (we) lost saw the deceased alive on <b>9/23, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Daniel Rosenblum MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/24/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL ROSENBLUM, MD</b>		22e. ADDRESS <b>10400 Connecticut Avenue Kensington, Md 20895</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9-25-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Prince Geo. Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b>		ADDRESS <b>5130 Wisc. Ave. N.W. Washington, D.C.</b>		DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		REGISTRAR'S SIGNATURE <b>Sam J. Gawler</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ADOLPHE</b>			FIRST MIDDLE LAST <b>POCIDALO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-12-83</b>			2b. HOUR <b>10<sup>15</sup> P M</b>					
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 13, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>France</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Wash.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Librarian(Ret)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Library</b>		
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>6121 Montrose Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Pocidalo</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cheva Ostrowski</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>380-30-3307</b>			17. INFORMANT ADDRESS <b>Samuel Roberts; 6121 Montrose Rd., Rockville Md.</b>								

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RESPIRATORY ARREST**

**5990**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **URINARY TRACT INFECTION**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**1 WEEK****10 DAYS**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 19</b> , 19 <b>81</b> , to <b>SEPT 12</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>SEP 12</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert L. Rosenberg</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/13/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. ROSENBERG, MD</b>				22e. ADDRESS <b>1131 UNIVERSITY BLVD. W, SILVER SPRING, MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-15-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Adas Israel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Danzansky-Goldberg Chapels, 1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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JAN 10 1910

NO. 10

RECEIVED



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. HOUR	
GEORGE W POORE		9 22 1983		12:00a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	Feb. 4 1929	54 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	U.S.A.		Montgomery MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital	Accountant	Giant Food		
13a. USUAL RESIDENCE (GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS		
13a. STATE 20910 13b. COUNTY Mont. 13c. CITY OR TOWN Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>	635 Ritchie Avenue 20910		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
George Ambrose Poore		Nellie Burrows			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes Korea		578-30-0932		Patricia S Poore, Same as item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a))					
4100 Due to, or as a consequence of					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) Due to, or as a consequence of					
(c) Due to, or as a consequence of					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
Cerebral edema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive and above (1) we (did) (did not) view the body after death.					
22b. SIGNATURE					
22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					
22e. ADDRESS					
Barton J. Gershen, M.D. 50 W. Edmonston Dr., Rockville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9/24/1983		Gate of Heaven Cem.	
23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Silver Spring Maryland		Silver Spring Maryland		CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR					
25a. DATE REC'D. BY REGISTRAR					
25b. REGISTRAR'S SIGNATURE					
25c. DATE REC'D. BY REGISTRAR					

BP



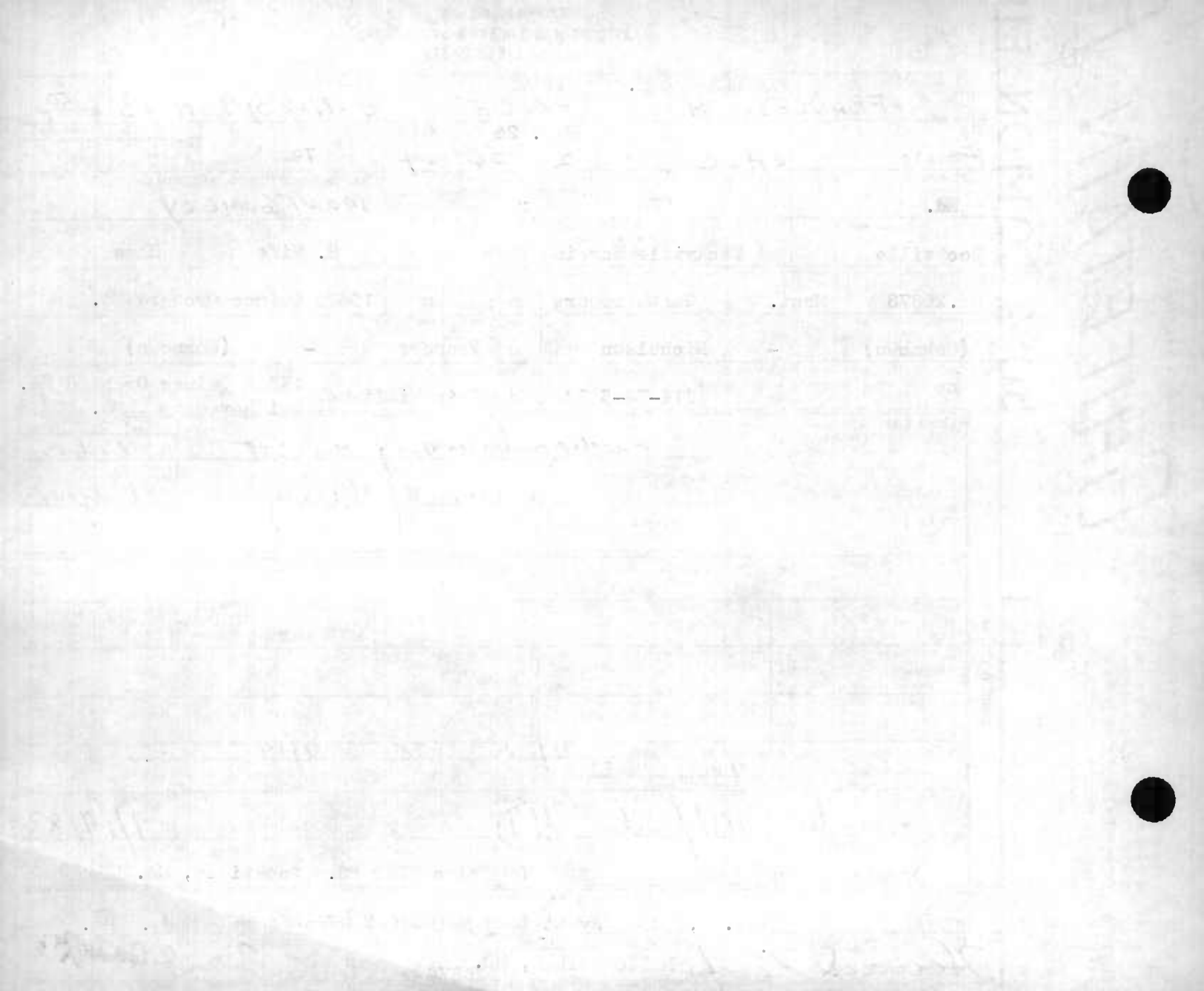


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST PRICE FRANCES H. PRICE				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 9-19-83 9 19 83 6:50 PM			
3. SEX Female		4. RACE CAUC		5. FEB. 26 1904 MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md. 20878		13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) - Nicholson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances - (Unknown)		13e. STREET ADDRESS 15829 Quince Orchard Rd.		20878	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-5238		17. INFORMANT ADDRESS Virginia Williams 15819 Quince Orchard Rd. Gaithersburg, Md. 20878			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cancer of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1629 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>78</u> , to <u>9/19</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>7/6</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frauke Westphal		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal		22e. ADDRESS 809 Veirs Mill Rd. Rockville, Md. 20850					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Sept. 22, 1983		23c. NAME OF CEMETERY OR CREMATORY Hyattstown Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattstown Mont. Md.	
24. FUNERAL DIRECTOR'S NAME Francis H. Barber		FURNERAL HOME LAYTONSVILLE, MD		25a. DATE REC'D. BY REGISTRAR SEP 26 1983		REGISTRAR'S SIGNATURE John J. Calkins	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME FIRST <u>MARTIN</u> MIDDLE <u>CEWARD</u> LAST <u>PRICE</u>					2a. DATE OF DEATH MONTH <u>9</u> DAY <u>26</u> YEAR <u>83</u>				
3. SEX <u>male</u>					4. RACE <u>WHITE</u>				
5. DATE OF BIRTH <u>APRIL 28, 1904</u>					6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Ohio</u>					7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.				
10. CITY OR TOWN OF DEATH <u>Bethesda</u>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Fork Lift Operator</u>					12b. KIND OF BUSINESS OR INDUSTRY <u>Freight Transportation</u>				
13a. STATE <u>Md.</u>					13b. COUNTY <u>Mont.</u>				
13c. CITY OR TOWN <u>Germantown</u>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13e. STREET ADDRESS <u>19145 St. Johnsbury Lane</u>					13f. STREET ADDRESS <u>20874</u>				
14. FATHER'S NAME FIRST <u>WILLIAM</u> MIDDLE <u>H.</u> LAST <u>PRICE</u>					15. MOTHER'S MAIDEN NAME FIRST <u>ANNA</u> MIDDLE <u>BREESE</u> LAST <u>BREESE</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>					16b. SOCIAL SECURITY NO. <u>300-01-5534</u>				
17. INFORMANT <u>S. David Price</u>					17. ADDRESS <u>Same as # 13</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <u>4254</u> IMMEDIATE CAUSE (a) <u>CARDIAC Myopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPTICEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEPTICEMIA</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/26/83</u> to <u>9/26/83</u> , that (I) (we) lost saw the deceased alive on <u>9/26/83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thos G. Ward</u>					22c. DATE SIGNED <u>9/26/83</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thos G. Ward</u>					22e. ADDRESS <u>6116 Robin wood, Bethesda, Md 20807</u>				
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>					23b. DATE <u>SEPT. 29, 1983</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>					23d. LOCATION CITY OR TOWN COUNTY STATE <u>Laytonsville Mont. Md.</u>				
24. FUNERAL DIRECTOR NAME <u>FRANCIS H. BARBER</u> ADDRESS <u>LAYTONSVILLE, MD. 20879</u>					25a. DATE REC'D. BY REGISTRAR <u>SEP 29 1983</u>				
25b. REGISTRAR'S SIGNATURE <u>Francis H. Barber</u>					25c. REGISTRAR'S SIGNATURE <u>Francis H. Barber</u>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Eugenia H. Protzman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-16-83</b>			2b. HOUR <b>1:45AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPTEMBER 27, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>GAITHERSBURG</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A. Wilson Health Care Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. SCHOOLS</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM EUGENE HERBERT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARION ESTELLE CARTER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-62-1639</b>		17. INFORMANT <b>ARTHUR CARTER, NEPHEW, ROCKVILLE, MD. 20853</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**7289**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

**Progressive muscular weakness of**DUE TO, OR AS A CONSEQUENCE OF **uncertain etiology**

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**2 days.****1 year.**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**Spinal compression with paraplegia, osteoarthritis**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>Dec 30, 1981</b> , to <b>Sept 16, 1983</b> , that (1) (we) last saw the deceased alive on <b>Sept 6, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.							
22b. SIGNATURE <b>James R. Moore Jr.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-16-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Moore Jr.</b>				22e. ADDRESS <b>207 Brookes Ave Gaithersburg Md.</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>9/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND PG. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>RICHARD RAPP, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>J. Carter</b>	
1120 CONN. AVE., N.W. #940, WASH., D.C. 20036							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT ANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Handwritten notes at the top of the page, including "100-40-100" and "100-40-100".

Handwritten notes in the middle section, including "100-40-100" and "100-40-100".

Handwritten notes in the lower middle section, including "100-40-100" and "100-40-100".

Handwritten notes at the bottom of the page, including "100-40-100" and "100-40-100".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. FOR STATE REGISTRAR			24952					
1. DECEASED NAME (TYPE OR PRINT) <u>William E Rathiff</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>September 24, 83</u>		2b. HOUR <u>0823</u> M.			
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>12 14 1911</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY, MD.</u>		
10. CITY OR TOWN OF DEATH <u>ROCKVILLE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Shady Grove Adventist Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>Montg.</u>		13c. CITY OR TOWN <u>Poolesville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>20831 14941 Sugarland Rd.</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph S. Rathiff</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elizabeth Catron</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO. <u>229-03-8999</u>		17. INFORMANT ADDRESS <u>Mrs. E. S. Eader - Poolesville Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <u>4960</u> IMMEDIATE CAUSE (a) <u>Chronic Obstructive Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Bronchogenic Carcinoma, Pneumonia</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/7</u> , 19 <u>83</u> , to <u>9/24</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Michael Summer</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/24/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>9/27/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <u>Beallsville Montg. Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Wm. C. Helt</u> ADDRESS <u>Barnesville Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 28 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>				

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU HAVE ANY COMMENTS, WRITE THEM IN PENCIL IN THE SPACE PROVIDED. IF YOU HAVE ANY COMMENTS, WRITE THEM IN PENCIL IN THE SPACE PROVIDED. IF YOU HAVE ANY COMMENTS, WRITE THEM IN PENCIL IN THE SPACE PROVIDED.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24953	
1. DECEASED NAME (TYPE OR PRINT) <b>Alvin William Reid</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Sept 17 1983</b>		2b. HOUR MIN <b>1145</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Sept 17 1983</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 22 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Monterey</b>	
10. CITY OR TOWN OF DEATH <b>Tek Park</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wesley Hall Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Management</b>		12b. KIND OF BUSINESS <b>Industry</b>	
13a. STATE <b>Md</b>						13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Otho H. Reid</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gracie Conard</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>N/A</b>				16b. SOCIAL SECURITY NO. <b>578-03-5659</b>		17. INFORMANT ADDRESS <b>Estelle A. Reid-wife- (same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Yr</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>DME</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>				ADDRESS <b>1919 Seminary Rd. S.S. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>9-20-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Prince Georges Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>				ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 20 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

Virginia

USA

Industrial  
Industry

Manufacturing

xxxx

Cont. 1/2

Grain

Field

E.

Oct 0

W/A

W/A

278-03-2622

Patricia A. Held-vite- (name as 120)

W/A  
W/A  
W/A

W/A  
W/A  
W/A

1910 Cemetery, W. E. E. M.

John C. Rogers, III

1-20-02

Burial

Fort Lincoln Cemetery

Brenwood

Prince Georges M.

11000 E. Ave.,

Silver Spring, Md.

Mrs. Elizabeth Rogers

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT (PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						2. DATE KNOWN OF DEATH					
1. DECEASED NAME (TYPE OR PRINT) <b>KEVIN RICKETT</b>						2. DATE KNOWN OF DEATH <b>9-29-83</b>					
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Aug/ 23/1961</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>22 RS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2. DATE PRONOUNCED DEAD <b>9-29-83</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>					
10. CITY OR TOWN OF DEATH <b>Takoma Pk.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>			
13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5600 Chillum Pl. N.E.</b>			
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>David Lee Rickett</b>						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Emogene Swann</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215/90/5865</b>		17. INFORMANT ADDRESS <b>5600 Chillum</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. APPROXIMATE TIME OF DEATH <b>11:PM 9-29-83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <b>1436 Kanawha St. Langley Pk, Maryland</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Margareta Korell</b>				M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>9-30-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10/06/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Suitland, Md. PG County</b>			
24. FUNERAL DIRECTOR NAME <b>R.N. Horton</b>				ADDRESS <b>600 Kennedy St. NW Wash</b>				25. DATE REC'D BY REGISTRAR <b>OCT 17 1983</b>			
								25b. REGISTRAR'S SIGNATURE <b>James J. Conner</b>			

RECEIVED  
FEB 10 1964

OLSON FIBER

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>(RICKS) MARY HELEN RICKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 21 83</b>		2b. HOUR <b>2 20</b> PM		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 15, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip Jackson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Adams</b>		13e. STREET ADDRESS <b>95 Dawson Ave., #513</b>		13f. STREET ADDRESS <b>20850</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-12-1193</b>		17. INFORMANT ADDRESS <b>JOHN S. RICKS (husband) same as #13</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4100**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **PROBABLE CARDIOGENIC SHOCK**

DUE TO, OR AS A CONSEQUENCE OF

(c) **MYOCARDIAL INFARCT 1st PULMONARY EMBOLUS**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**MINUTES****HOURS****HOURS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

**SIP (R) Hemispheric CVA**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1980 April 80</b> to <b>Sept. 21</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>July 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alan R. Vinitzky</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/21/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN R. VINITZKY</b>		22e. ADDRESS <b>12116 DARNESTOWN RO.</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-26-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Darby Spring Montg Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		ADDRESS <b>246 N. Wash. St. Rockville, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>SEP 27 1983</b>		REGISTRAR'S SIGNATURE <b>Sham J. Carver</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

MEMORANDUM FOR THE SECRETARY OF DEFENSE

FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>MAUDE BELL RIGGS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 29 1983</b>				
3 SEX <b>Female</b>					4 RACE <b>white</b>				
5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 4, 1894</b>					6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>					7b CITIZEN OF WHAT COUNTRY? <b>USA</b>				
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Gaithersburg</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>22130 Goshen School Road</b>				
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H. Wife</b>					12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a STATE <b>MD.</b>					13b COUNTY <b>Mont.</b>				
13c CITY OR TOWN <b>Gaithersburg</b>					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>William - Bell</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Fedelia Warfield</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b SOCIAL SECURITY NO. <b>214-74-5859</b>				
17 INFORMANT <b>Joyce Hawkins</b>					22130 Goshen School Rd. <b>Gaithersburg, Md. 20879</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility - a systole</b> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Atherosclerosis, genl.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b> <b>Years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)					21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>47</b> to <b>9-29</b> , 19 <b>83</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>9-29</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) did not view the body after death.									
22b. SIGNATURE <b>Jack Schumacher</b>					22c. DATE SIGNED <b>Sept. 29, 1983</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. JACK SCHUMACHER</b>					22e. ADDRESS <b>RUSSELL AVE. GAITHERSBURG, MD. 20879</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>Oct. 1, 1983</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laytonsville Mont. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Francis H. Barber</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 03 1983</b>				
25b. REGISTRAR'S SIGNATURE <b>John J. Coniff</b>									

BP

Atmospheric, acc. 1  
C.V.D. 1/100  
Sensitivity - 0.25 to 1

1-27-52  
1/100  
1-27-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL Josephine RIGTER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9/23/83</b>					2b. HOUR <b>7:54 AM</b>
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 28 1904</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Health Care Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hpme</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>14820 Shady Grove Road 20850</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Walter Mills</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertie West</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-42-7029</b>		17. INFORMANT ADDRESS <b>Mt. Airy, Md. 21771</b> <b>Mary A. Reed 13210 Gerlach Court</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CHRONIC BRAIN SYNDROME</b>										
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from <b>8/13</b> , 19 <b>83</b> , to <b>9/23</b> , 19 <b>83</b> , that (1) we last saw the deceased alive on <b>8/13</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we did not view the body after death.										
22b. SIGNATURE <b>Ralph M. Coan</b>					DEGREE <b>M.D.</b>		22c. DATES SIGNED <b>9/23/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RALPH COAN M.D.</b>					22e. ADDRESS <b>4400 E.W. HWY, BETHESDA, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/26/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Rockville Montgomery</b>		23e. MD.		
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canich</b>			
1331 Rockville Pike Rockville, Maryland 20852										

BP

LETTER FROM THE DIRECTOR

TO THE BOARD OF DIRECTORS

1904

RE: THE PROPOSED CHANGES IN THE BY-LAWS

AND THE AMENDMENTS TO THE ARTICLES OF ASSOCIATION

AS SUBMITTED BY THE BOARD OF DIRECTORS AT ITS MEETING

HELD AT THE CITY OF CHICAGO, ILLINOIS, ON

THE 15TH DAY OF JANUARY, 1904.

YOUR LETTER OF THE 10TH INSTANT HAS BEEN RECEIVED

AND THE MATTER IS UNDER CONSIDERATION

OF THE BOARD OF DIRECTORS

AND IT IS THE POLICY OF THE BOARD

TO CONSIDER THE MATTER AT ITS NEXT MEETING

HELD AT THE CITY OF CHICAGO, ILLINOIS, ON

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Sarah J. Rinehart			2a. DATE OF DEATH MONTH DAY YEAR Sept. 11, 1983			2b. HOUR 6:30 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 12 1913		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Chevy Chase,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8734 Preston Place zip 20815		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland Montgomery				13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Walton Rinehart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Alice Mooney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216 44 4133		17. INFORMANT ADDRESS Fort Pierce, Fla Madelyn R. Owers, Rt#4 Box 107 zip 33450			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>							
19a. DATE OF OPERATION 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of breast		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>70</u> to <u>present</u> , 19 _____, that (I) (we) lost saw the deceased alive on <u>9/11</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John B. Umhau</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umhau, MD		22e. ADDRESS 8805 Connecticut Av. Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1983 Sept. 14,		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring, Md		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 15 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly executed, it should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and a table on lined paper. The notes are mostly illegible due to fading. A table with multiple columns and rows is visible in the lower half of the page. Two large black circular marks are present on the right side of the page.

DATE	DESCRIPTION	AMOUNT
1917	...	...
1918	...	...
1919	...	...
1920	...	...
1921	...	...
1922	...	...
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DR. ROGERS

DIVISION OF VITAL RECORDS, 201 W. HESTON ST., BALTIMORE, MARYLAND 21201

Release By medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edith M. Roberts</b>				2b. HOUR MIN. <b>12:58 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 12 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>87 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisc.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md. 20815</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick C. Roberts</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Cogswell</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>195-24-4118</b>		17. INFORMANT ADDRESS <b>Doris E. Roberts 6111 Kennedy Dr. Chevy Chs. Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senile Generalized Arteriosclerosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. <b>4409</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral Vascular Arteriosclerosis</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>— — — — —</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1, 1983</b> to <b>Sept 3, 1983</b> , that (I) (we) last saw the deceased alive on <b>9-2-83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (do) view the body after death.							
22b. SIGNATURE <b>P. P. Andrews MD for Registrar</b>				22c. DATE SIGNED <b>9-3-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. P. ANDREWS MD</b>				22e. ADDRESS <b>4577 Battery La Bethesda Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/6/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b>				24b. DATE RECD. BY REGISTRAR <b>SEP 13 1983</b>			



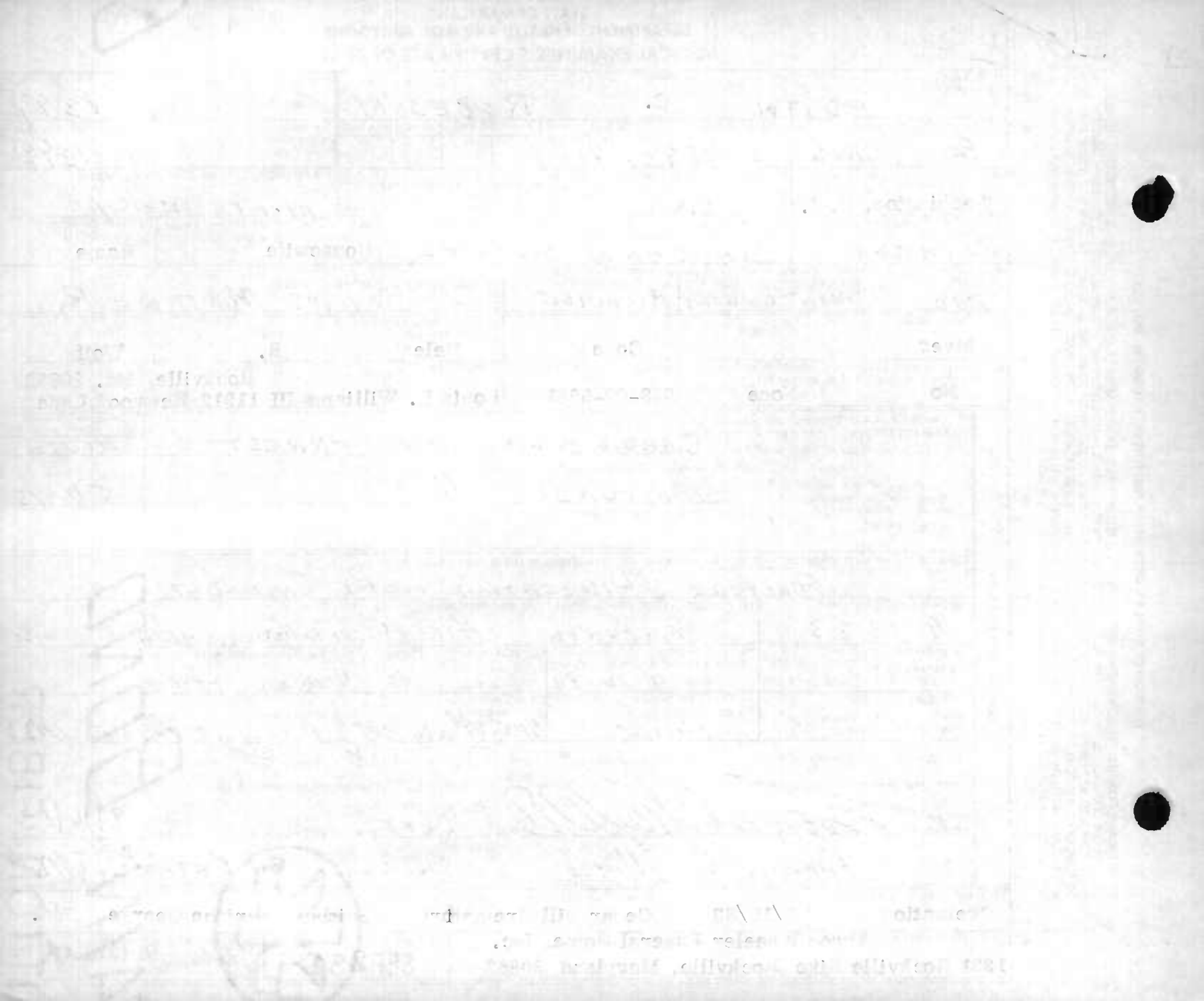


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24760	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDITH C. ROBESON</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 16 1983</b>		2b. HOUR <b>905 PM</b>		
3. SEX <b>F</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 18 93</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>90</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 16 1983</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD</b>		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6105 MONTROSE RD 20852</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Myer Cohen</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen R. Wolf</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>579-62-9881</b>			17. INFORMANT ADDRESS <b>Louis L. Williams III 11912 Renwood Lane Rockville, Md. 20852</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8880 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>(b) FRACTURED HIP</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>5 DAYS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>FRACTURE DISLOCATION LEFT SHOULDER</b>											
19a. DATE OF OPERATION <b>9 13 83</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>FRACTURED HIP / CLOSED REDUCTION</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>9 12 1983</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>FELL AT NURSING HOME</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6105 Montrose Rd Rockville MONT MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Francis C. Mayo</b>			TITLE (SPECIFY) <b>DEPT</b>			M.D. <b>DEPT</b>			DATE SIGNED <b>9/16/83</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C. Mayo</b>			ADDRESS <b>8200 Wisconsin Ave BETHESDA MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>9/19/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Prince George Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			
1331 Rockville Pike Rockville, Maryland 20852											



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Sallie G. Rode</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9-1-83</i>			2b. HOUR <i>10<sup>15</sup> AM</i>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 27 1887</i>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6700 Belcrest Road 20782</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel C. Goggin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lizzie D. Moon</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Sara E. Rode - daughter - (same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5860</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardiovascular breakdown</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>renal failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 to 3 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <i>Status post fracture femur 1982-</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>8-9</i> , 19 <i>83</i> , to <i>9-1</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>9-1</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Roderic M. Brennan</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9-1-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Fu. BRENNAN</i>						22e. ADDRESS <i>831 University Blvd E. Silver Spring</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-6-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Georges Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>				ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

BP

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Yarns

White

Feb. 27

1897

96

Virginia

MA

Montgomery

Takoma Park

Washington & Ventnor Hospital

School Teacher, Indian School

Maryland

Dr. George Hyattsville

x

8700 Belcrest Road

20782

Samuel

D.

Gordon

Lizette

D.

Moore

MA

MA

126-42-1981

Boys F. Foster-daughter - (name as 196)

20% CR

United

1-6-1983

Fort Lincoln Cemetery Greenwood Rt. 2000 Md.

11300 N.H. Ave.

Silver Spring, Md.

Shaw, Richard Internal Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified in order to conduct an autopsy.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 24962			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST <b>Joan K. Rogers</b>				2b. HOUR <b>1:36A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 13, 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>50 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF SERVICE FOR MOST OF WORKING LIFE) <b>Own Business</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Zip Code - <b>9817 Worrell Ave. 20769</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George T. Kelly</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Ammann</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN, IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>577-44-5664</b>		17. INFORMANT <b>Mr. William H. Rogers</b>		ADDRESS Address Same as No#13c.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Lung Cancer</b> 3 months DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>30 June 1983</b> , to <b>8 Sept 1983</b> , that (1) (we) last saw the deceased alive on <b>30 June 1983</b> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas A. Bersinger</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/8/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas A. Bersinger</b>		22e. ADDRESS <b>7676 New Hampshire Ave Landover MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 12, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Washington, D.C. 20783</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>SEP 13 1983</b>			

BP

RECEIVED  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

10

September 1, 1954

Mr. J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C.

Dear Mr. Hoover:

I am writing to you regarding the matter of the

U.S. Department of Justice, which has been

the subject of my recent report to you.

I am sure that you will find the information

contained in my report to be of interest to you.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 24963			
1. FOR STATE REGISTRAR				1. DECEASED NAME FIRST MIDDLE LAST Anton M Rose			
2a. DATE OF DEATH MONTH DAY YEAR 9-17-83				2b. HOUR 9:05 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 14 08		6. AGE IN YEARS (LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? GERMANY		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS 3920 HIGHVIEW DRIVE (20986)			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST (UNKNOWN)				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MR. RAINER ROSE 3475 OLYMPIA RD. DAVIDSONVILLE MD 21035			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of Gallbladder</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks. months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/5</u> , 19 <u>83</u> , to <u>9/17</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Marvin Schneider</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/17/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN SCHNEIDER M.D.				22e. ADDRESS 12001 Fenwick Ave, Wheaton, Md 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE SEPT/20/83		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. CO. MARYLAND	
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME				ADDRESS SILVER SPRING, MARYLAND		25a. DATE REC'D. BY REGISTRAR SEP 22 1983	
				25b. REGISTRAR'S SIGNATURE <u>P. J. Connelley</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>PHILIP ROSENBERG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 8, 1983</b>		2b. HOUR <b>6:30p<sub>M</sub></b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 8, 1934</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10401 Grosvenor Place</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NCR Co.</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Rockville</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jack Rosenberg</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Magerman</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes unk/</b>		
16b. SOCIAL SECURITY NO. <b>166-28-4246</b>		17. INFORMANT <b>Jeffrey Chernow; 24 Baroness Court</b>		17a. ADDRESS <b>Owings Mills, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4279 Suspected Ventricular Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE <b>79 9/8 83</b>		
22a. I certify that (1) (this hospital) attended the deceased from 19 <b>83</b> , to 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1)(we) did (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <b>9-9-1983</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOEL L. GOOZH, M.D.</b>		22e. ADDRESS <b>4701 Randolph Road; Rockville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-11-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shalom Memorial Park Philadelphia, Pa.</b>		
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>		24b. ADDRESS <b>Rockville, Md.</b>		24c. DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>		
24d. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
HARRY			ROSENTHAL			SEPT 29 1983 6:10p.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR		
Male	White	June 30, 1890	93			6:10p.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Russia	U.S.A.		Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	Potomac Valley Nursing Home			Plate Printer			U.S. Gov't.	
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Maryland			Montgomery			Bethesda		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
(UNKNOWN)			(UNKNOWN)			NO		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
029-07-0941			Jacob V. Golder; 6000 Berkshire Dr.; Bethesda,			Maryland 20814		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PARKINSONS DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>25 SEPT 83</u> to <u>29 SEPT 83</u> , that (I) (we) lost saw the deceased alive on <u>25 SEPT 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.		22b. SIGNATURE <u>Walter E. Goetz MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>29 SEPT 83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER E. GOETZ MD</u>		22e. ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	10/2/83	Judean Memorial Gardens	Olney; Montgomery; Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
DANZANSKY-GOLDBERG MEMORIAL CHAPELS		OCT 03 1983	
1170 Rockville Pike; Rockville, Maryland 20852		REGISTRAR'S SIGNATURE <u>John E. Curren</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		9-21-83		0227 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White,		Oct. 27, 1904		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Montgomery County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Gaithersburg		Shady Grove Hospital		Teller		Bank	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		Montgomery		Gaithersburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		407 Russell Avenue 20877			
George G. S. Reus, Sr.		Florida S. Streckfus					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		217 14 5535		Mr. Chris Rupp, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Gastrointestinal bleeding with anemia</u>		5 days					
4148							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Multiple cerebrovascular accidents</u>		3 weeks					
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>Multiple myocardial infarctions</u>		1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
<u>Hepatocellular disease of uncertain type, COPD</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 20</u> , 19 <u>80</u> , to <u>Sept 21</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept 20</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.		22c. DATE SIGNED					
22b. SIGNATURE		DEGREE		22d. ADDRESS			
<u>James R. Moore Jr.</u>		MD		201 Brookes Ave Gaithersburg Md.			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		9/26/83		Druid Ridge		Pikesville, MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co.		SEP 22 1983		John J. Carver			
4905 York Road Balto., MD 21212							

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician.  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
REG. NO. 24967										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Rose</u> <u>Ruff</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>9</u> <u>24</u> <u>83</u>					2b. HOUR <u>5</u> <sup>PM</sup>
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3</u> <u>14</u> <u>96</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>87</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>England</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.		
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Secretary (Ret)</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Chair Co.</u>	
13a. STATE <u>Md</u>		13b. COUNTY <u>Mont.</u>		13c. CITY OR TOWN <u>Wheaton</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>2344 Glenmont Circle</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Elias</u> <u>Jacobowitz</u> <u>Kaila</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>(unknown)</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>					16b. SOCIAL SECURITY NO. <u>055-20-2570A</u>		17. INFORMANT ADDRESS <u>Irwin S. Ruff; 14421 Barkwood Dr., Rockville Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4310</u> IMMEDIATE CAUSE (a) <u>Right cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>September 1, 1983</u> to <u>September 24, 1983</u> , that (I) (we) lost above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>Deborah B. Goldberg</u>					DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/24/83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DEBORAH B. GOLDBERG, M.D.</u>					22e. ADDRESS <u>1106 Spring St., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>9-26-1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church, Va.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <u>Danzansky-Goldberg Chapels; 1170 Rockville Pike</u>					25a. DATE REC'D. BY REGISTRAR <u>SEP 28 1983</u>		25b. REGISTRAR'S SIGNATURE <u>Sam J. Carver</u>			

BP



FOR  
STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Saleh I. Saleh</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>Sept 21 1983</b>			2b. HEALTH <b>128</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 05 78</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>05</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN <b>0</b>	IF UNDER 24 HRS. HOURS MIN <b>0</b>	7c. DATE PRONOUNCED DEAD <b>Sept. 21 1983</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Palestine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kelly Cross Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Mt. Rockville</b>			13b. STATE <b>MD</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>15124 Red Clover Dr.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ibrahim Saleh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Azziza George</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NONE</b>			16b. SOCIAL SECURITY NO. <b>218 54 9981</b>		17. INFORMANT ADDRESS <b>Ibrahim Saleh (Son) Same as #13E</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Myocardial Disi</b> 8589 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Drug Reaction</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOURS MIN MONTH DAY YEAR <b>1:15 P.M. 19 83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Hospital</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1500 Forest Glen Rd. Silver Springs, Md</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John S. Rogers</b>			TITLE (SPECIFY) <b>Dep.</b>			MEDICAL EXAMINER		DATE SIGNED <b>Sept 21 1983</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>			ADDRESS <b>1919 Seminary Rd. S.S.Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/24/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>S.S. Mont. Maryland</b>	
24. FUNERAL DIRECTOR <b>Hines/Rinaldi 11800 N.H.Ave.S.S.Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM THAT REMAINS PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS - 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



CHINA

1936/1/10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
PANI		SAMET		Sept. 3, 1983		12:15pm	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	White	Sept. 23, 1904		78 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Hungary	USA			Montgomery MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Sil. Spring	Holy Cross Hospital			Housewife		-----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13e. STREET ADDRESS				
Maryland	Montg.	Sil. Spg.	1121 University Blvd. West 20902				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Benjamin Katz		Judith (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		097-36-0021D		Leo Samet; 1121 Univ. Blvd. W., SSpGMD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE 4310 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3 JAN 1974, to 3 SEPT 1983, that (I) (we) lost saw the deceased alive on 3 SEPT 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hubert J. Alpert		DEGREE M.D.		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-3-1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
HUBERT J. ALPERT, M.D.		8630 Fenton Street; Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial	9-4-1983	Geo. Wash. Cemetery		Hyattsville, Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Danzansky-Goldberg Chapels;		1170 Rockville Pike		SEP 9 1983		John J. Connel	

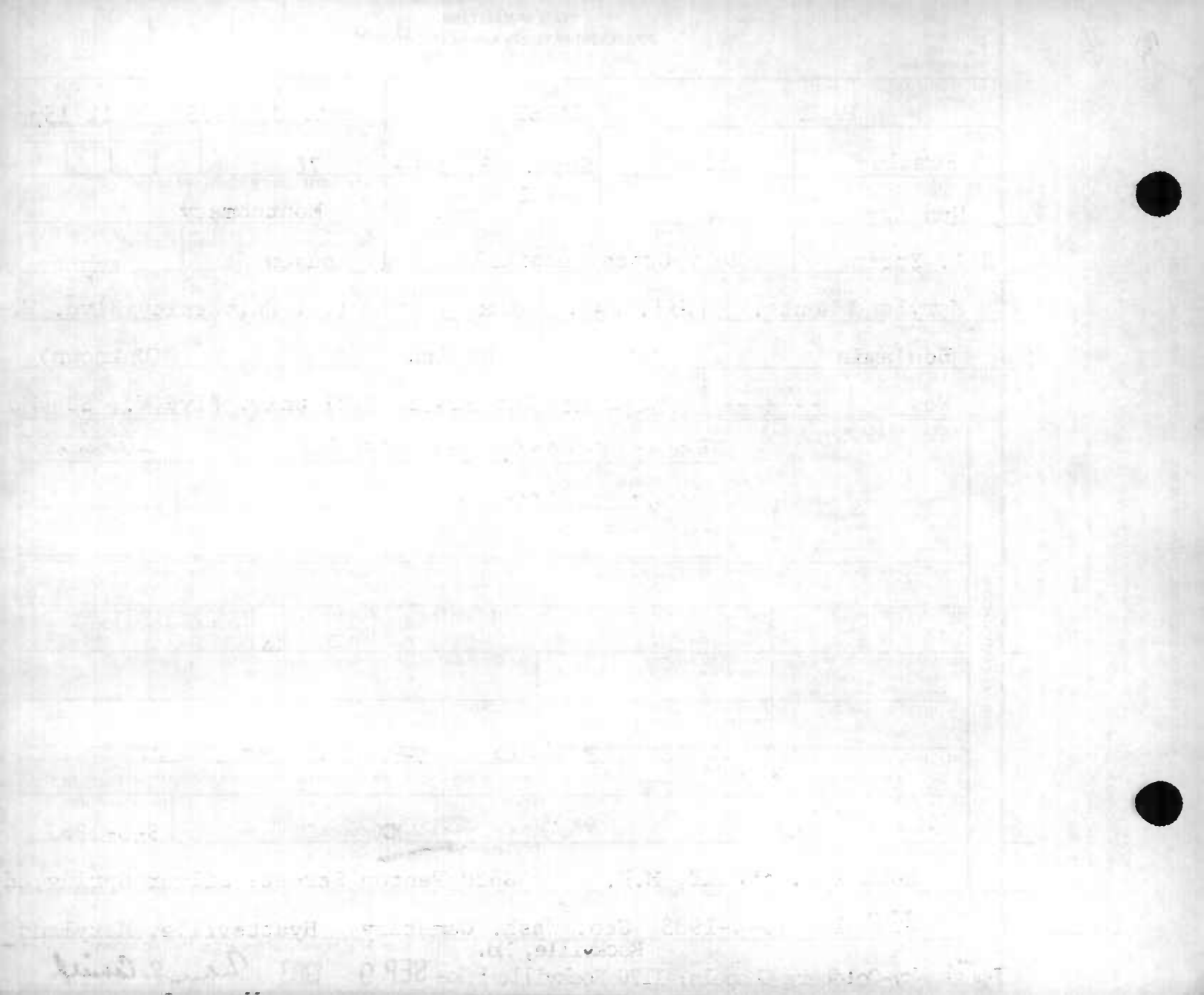
Examiner must be notified at once

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH MATTHEW SANTORO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 27 1983</b>		2b. HOUR <b>5:03 a.m.</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 10 1907</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RHODE ISLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LT. COL.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3491 S. LEISURE WORLD BOULEVARD</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>NAZARANO SANTORO</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VIRGINIA NISTA</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1930-1950</b>	17. INFORMANT ADDRESS <b>MARGARET A. SANTORO, 3491 S. LEISURE WORLD BLVD.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RESPIRATORY FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 6, 1983</b> , to <b>SEPTEMBER 27, 1983</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 27, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>R.K. Ferguson</i>	DEGREE <b>LT, MC, USNR</b>	22c. DATE SIGNED <b>27 SEP 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.K. FERGUSON, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>SEP. 30, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARLINGTON VIRGINIA</b>
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 3 1983</b>	25b. REGISTRAR'S SIGNATURE <i>John G. Smith</i>
26. ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

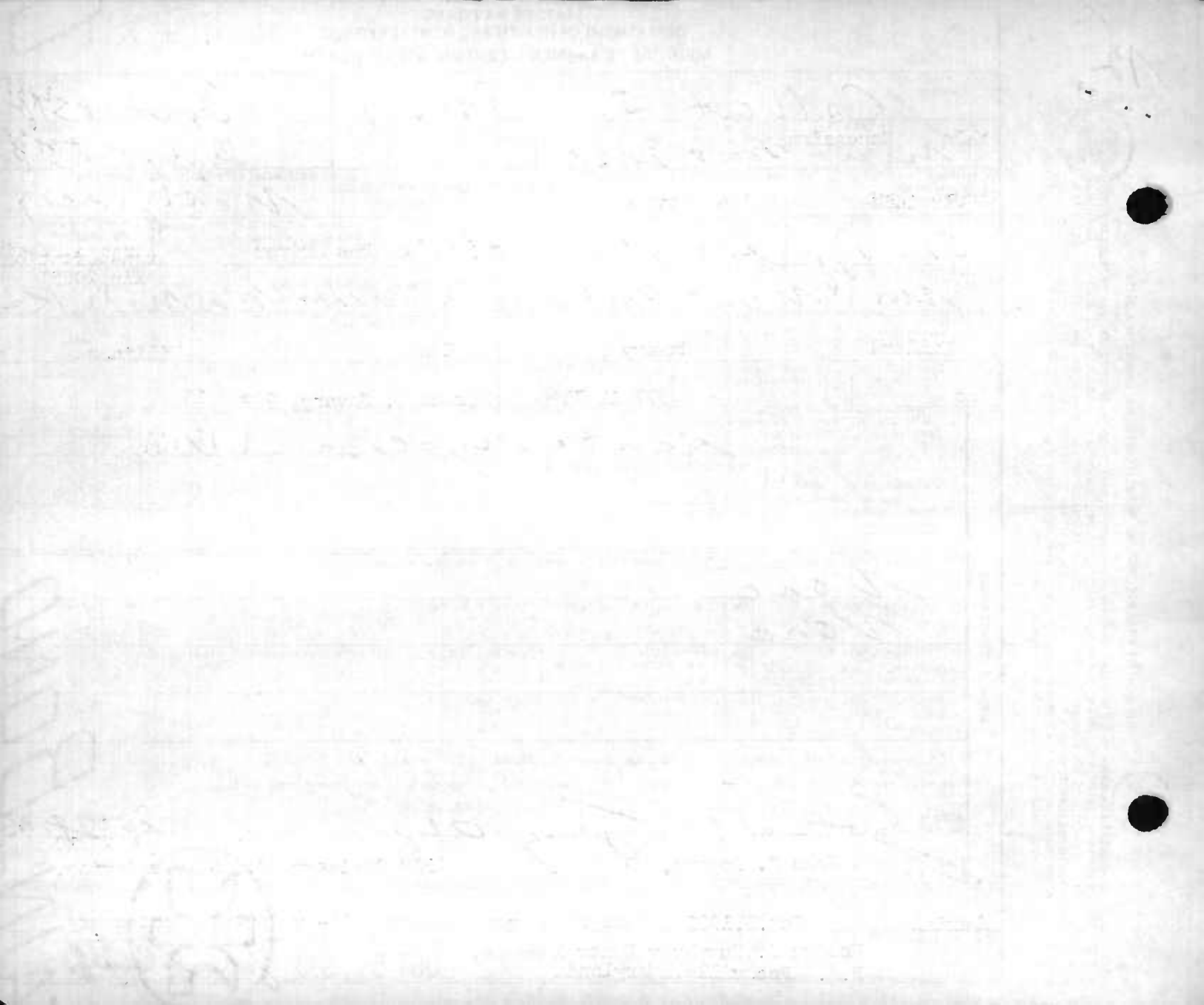
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										24971 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>Calvert J. Savary</b>							2a. DATE KNOWN OF DEATH MONTH <b>09</b> DAY <b>28</b> YEAR <b>1983</b>					
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>5</b> YEAR <b>1963</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>20</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>		
10. CITY OR TOWN OF DEATH <b>St. Louis</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Louis Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bus Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		
13a. STATE <b>MD</b>				13b. CITY OR TOWN <b>Rockville</b>				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1114 Glen Mill Rd</b>		
14. FATHER'S NAME FIRST <b>Willard</b> MIDDLE <b></b> LAST <b>Savary</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b></b> LAST <b>Williams</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>577 12 7098</b>				17. INFORMANT ADDRESS <b>Lorene M. Savary, see # 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>Acute Myocardial Dis</b> 4291 DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>												
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET <b></b>		CITY OR TOWN <b></b>		COUNTY <b></b> STATE <b></b>		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <b>John S. Rogers, MD</b>				TITLE (SPECIFY) <b>MD</b>				MEDICAL EXAMINER DATE SIGNED <b>Sept 28 1983</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, MD</b>				ADDRESS <b>1919 Seminary Rd., Silver Spring, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Oct. 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Silver Spring, Montgomery, MD</b>		
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 5 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Houston Thomas Savage				9 3 83	
3 SEX	M	4. RACE	Negro	5. DATE OF BIRTH MONTH DAY YEAR	75 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Virginia	7b. CITIZEN OF WHAT COUNTRY?	U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
10. CITY OR TOWN OF DEATH	Gaithersburg, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Home - 17134 Downing St.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
12a. USUAL OCCUPATION	Bus-driver	12b. KIND OF BUSINESS OR INDUSTRY	School		
13a. STATE	Md.	13b. COUNTY	Mont.	13c. CITY OR TOWN	Gaithersburg
14. FATHER'S NAME FIRST MIDDLE LAST	John T SAVAGE	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Hattie T SAVAGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	No	16b. SOCIAL SECURITY NO.	223-09-7352	17. INFORMANT	17134 DOWNING ST Apt 303
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2500		Cardio pulmonary arrest			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) end stage diabetes mellitus			
		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Recent Congestive Heart Failure					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Charles W. Karash MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		9/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
KARESH		15 E. Oakpark Drive, Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	9-10-83	Holy Trinity	Painter ASCOMACK, VA.		
24. FUNERAL DIRECTOR NAME ADDRESS					
Edgar Wharton - Accomack, Va. 23301					

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Mr. Wm. T.

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Charles W. Kersh

Charles W. Kersh

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>James Riehl Saylor JR.</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>23</b> YEAR <b>83</b> 2b. HOUR <b>5 25am</b>		
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>20</b> YEAR <b>38</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>analyst</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>IBM</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13a. CITY OR TOWN <b>Montgomery</b> 13a. CITY OR TOWN <b>Kensington</b>					
14. FATHER'S NAME <b>JAMES R SAYLOR SR</b>		15. MOTHER'S MAIDEN NAME <b>BERTHA MIDDLE HOFFA</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1956-1962 215-36-3651</b>		17. INFORMANT ADDRESS <b>ADA JOHANNE SAYLOR SAME AS 13c 20895</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4275 Cardiac Arrest</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute cardiac rejection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>					
19a. DATE OF OPERATION <b>9/23/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b></b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>19 77</b> to <b>9/24</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>6/30</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE <b>Steven K. Kaufman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/23/83</b>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN K. KAUFMAN</b>		22b. ADDRESS <b>106 IRVING ST NW WASH DC 20010</b>		22c. DATE SIGNED <b>9/23/83</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>SEPT 25, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY ALEXANDRIA FAIRFAX VA.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIVERSITY BLVD. WEST, SILVER SPRING, MD 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER A SCHULTZ		2a. DATE OF DEATH MONTH DAY YEAR 9 8 1983		2b. HOUR 11A M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 10 29 1918		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NAVY DEPT.	12b. KIND OF BUSINESS OR INDUSTRY ELECTRONICS ENG
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HENRY SCHULTZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA SUSOTT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS IONE H. SCHULTZ same as 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 9/8 83, that (I) (we) last saw the deceased alive on 9/5 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.				
22b. SIGNATURE DEGREE		22c. DATE SIGNED 9/8/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. ELG, M.D.		22e. ADDRESS 9801 Georgia Ave, Silver Spring, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE SEPT. 9, 1983	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN	
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA ALEXANDRIA VA.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		24b. ADDRESS 500 UNIV. BLVD. W. SIL. SPG. MD. 20901		25a. DATE REC'D. BY REGISTRAR SEP 15 1983
25b. REGISTRAR'S SIGNATURE John J. Carroll				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FRANCIS J. COLLINS  
500 W. 11th St.  
SEATTLE, WA 98101

SEPT. 9, 1983 METROLOGITAN

ALEXANDRIA ALEXANDRIA VA.



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JOHN W. SCHWARTZ

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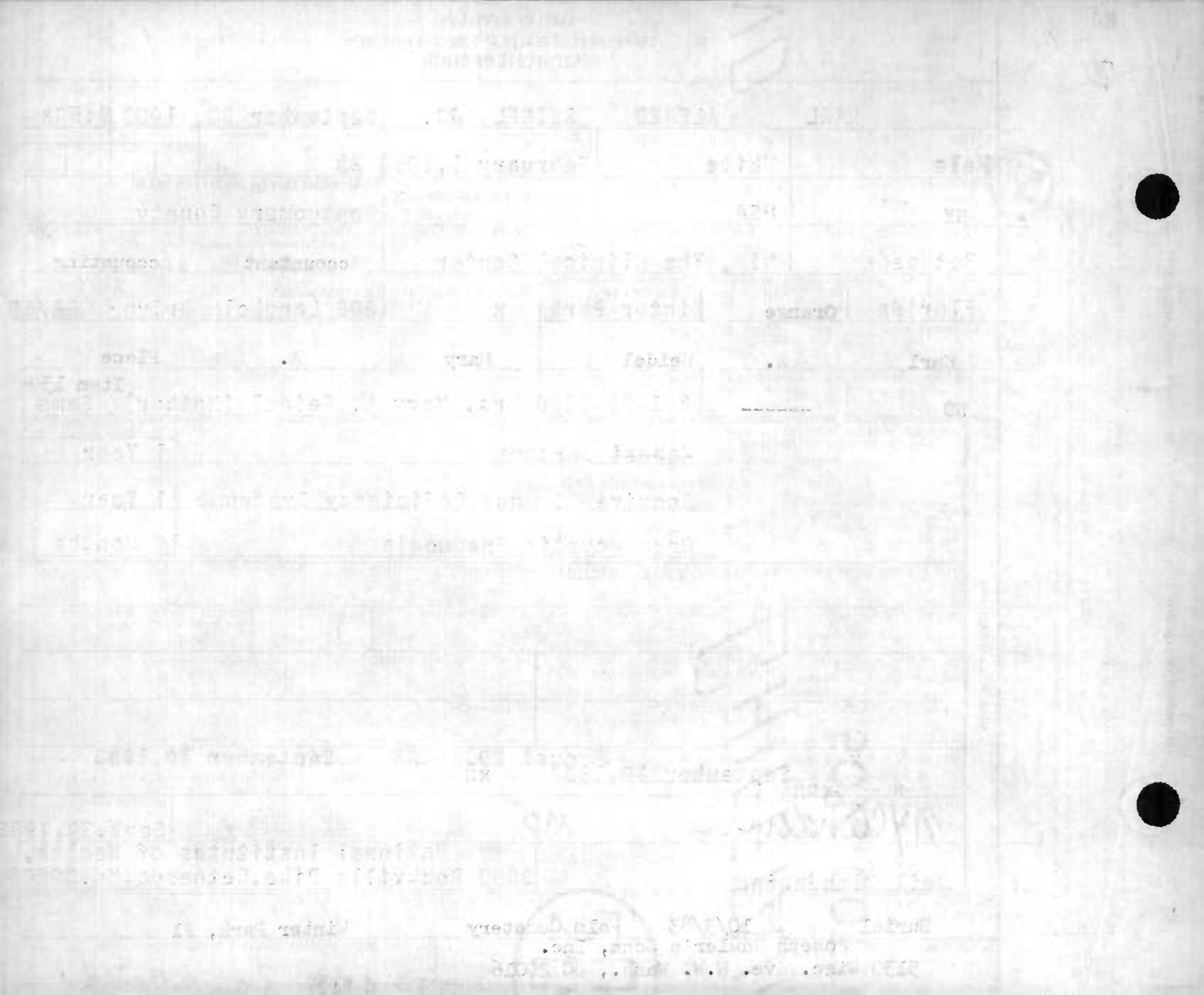
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>KARL ALFRED SEIDEL, JR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 30, 1983</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 1, 1950</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>33</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH, The Clinical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Florida</b>		13b. COUNTY <b>Orange</b>		13c. CITY OR TOWN <b>Winter Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>600 Langholm Drive</b>		13f. ZIP CODE <b>32789</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Karl A. Seidel</b>			
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		14b. SOCIAL SECURITY NO. <b>261-86-3390</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary A. Place</b>			
16a. INFORMANT ADDRESS <b>Mrs. Mary A. Seidel (Mother)</b>				16b. ITEM 13 <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1739</b> IMMEDIATE CAUSE (a) <b>Kaposi Sarcoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Acquired Immune Deficiency Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumocystis Pneumonia</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b> <b>1 Year</b> <b>10 Months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 29, 1983</b> to <b>September 30, 1983</b> and that in my (a) (my) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Neil Clendeninn</b> MD				22c. DATE SIGNED <b>Sept. 30, 1983</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Neil Clendeninn</b>				22e. ADDRESS <b>National Institutes of Health, 9000 Rockville Pike, Bethesda, Md. 20205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/3/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Palm Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Winter Park, FL</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> NAME ADDRESS <b>5130 Wisc. Ave. N.W. Wash., DC 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>10/1/83</b> REGISTRAR'S SIGNATURE <b>John A. Smith</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Benson Shawn					2a. DATE OF DEATH MONTH DAY YEAR 09 15 '83			2b. HOUR 2:30AM		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Dec 23, 1931		6 AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		9. CITIZEN OF WHAT COUNTRY? United States		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
12. CITY OR TOWN OF DEATH Olney		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consultant		15. KIND OF BUSINESS OR INDUSTRY Economics		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland					16b. COUNTY Montgomery		16c. CITY OR TOWN Rockville		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17. FATHER'S NAME FIRST MIDDLE LAST George Shawn					18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Benson					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1954-1956		19c. INFORMANT Ruth W. Shawn		19d. ADDRESS see # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1509 IMMEDIATE CAUSE (a) METASTATIC ESOPHAGEAL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from MARCH 19 83, to SEPT 15, 19 83, that (I) (we) lost saw the deceased alive on SEPT 15, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Eugene P. Flannery, MD					DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN			22c. DATE SIGNED 9/15/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY					22e. ADDRESS 18111 PRINCE PHILIP DR. OLNEY, MARYLAND 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Sep 15, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria			23d. LOCATION CITY OR TOWN COUNTY STATE Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey, Funeral Homes, P.A. Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR SEP 19 1983			25b. REGISTRAR'S SIGNATURE [Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

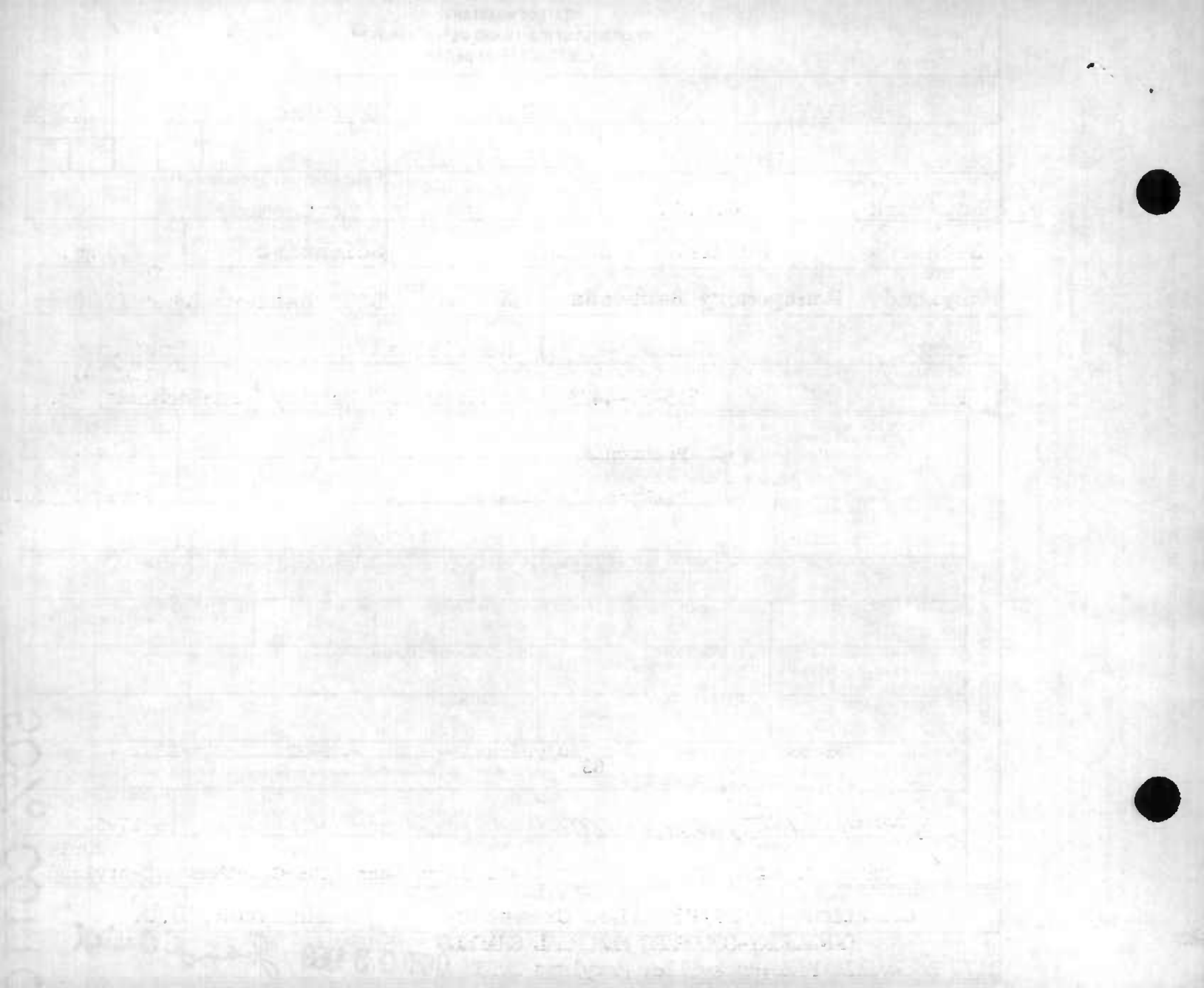
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 24977					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MURRAY J. SHEAR</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>September 27, 1983</b>			2b. HOUR <b>12:35pm</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 7, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Scientist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N.I.H.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Victor Shear</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Henrietta Robinson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WWI</b>					16b. SOCIAL SECURITY NO. <b>215-38-4423</b>		17. INFORMANT ADDRESS <b>Rose Shear; 5203 Battery Lane; Bethesda, Md. (20014)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>3320</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Parkinson's Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>Several years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9-27 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) ( <del>XXXXXX</del> ) attended the deceased from <b>20 years</b> , 19____, to <b>9-27</b> , 19 <b>83</b> , that (I) ( <del>xx</del> ) last saw the deceased alive on <b>9-27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>James W. Egan MD</i>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-27-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES W. EGAN, MD</b>						22e. ADDRESS <b>5413 Cedar Lane #206-C; Bethesda, Maryland 20814</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>9/29/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>067-031983 John J. Smith</b>				
1170 Rockville Pike; Rockville, Maryland 20852										

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BERNARD SHEVITZ</b>			2a. DATE OF DEATH <b>9/17/83</b>			2b. HOUR <b>5:40 P.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6/8/20</b>		6. AGE <b>63</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MINS.		
8. BIRTHPLACE <b>New York</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>				
12. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>			13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>			14. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>PRINTER</b>			15. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T.</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>SILVER SPRING</b>			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			18. STREET ADDRESS <b>673 KENBROOK DRIVE 20903</b>				
19. FATHER'S NAME FIRST <b>HARRY</b> MIDDLE <b>SHEVITZ</b> LAST <b>SHEVITZ</b>			20. MOTHER'S MAIDEN NAME FIRST <b>ROSE</b> MIDDLE <b>ANNENBERG</b>							
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b>			22. SOCIAL SECURITY NO. <b>217-03-8693</b>			23. INFORMANT <b>STEPHEN D. SHEVITZ, GREENBELT, MARYLAND</b>				

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**2028**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Cardiorespiratory Arrest**  
**Lymphoma**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**immediate**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>9/7</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>9/7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Aron Primack MD</b>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED <b>9/7/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARON PRIMACK</b>				22e. ADDRESS <b>106 IRVING ST., NW</b>			

23a. BURIAL, CREMATION, REMOVAL (USE CHECKS) <b>BURIAL</b>		23b. DATE <b>9/11/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON CEMETERY</b>		23d. LOCATION <b>PRINCE GEORGE'S, MARYLAND</b>	
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24. FUNERAL DIRECTOR <b>DOMINIC M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>		25. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>		26. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and a table at the top of the page. The table has several columns and rows of data, though the text is mostly illegible due to fading. Some visible words include "TABLE", "DATE", "TIME", "PLACE", "REMARKS", "WIND", "SEA", "TEMPERATURE", "HUMIDITY", "PRESSURE", "SPEED", "DIRECTION", "DISTANCE", "TIME", "PLACE", "REMARKS", "WIND", "SEA", "TEMPERATURE", "HUMIDITY", "PRESSURE", "SPEED", "DIRECTION", "DISTANCE".

Handwritten notes and a table at the bottom of the page. The table has several columns and rows of data, though the text is mostly illegible due to fading. Some visible words include "TABLE", "DATE", "TIME", "PLACE", "REMARKS", "WIND", "SEA", "TEMPERATURE", "HUMIDITY", "PRESSURE", "SPEED", "DIRECTION", "DISTANCE".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			24979			
1. DECEASED NAME (TYPE OR PRINT) <b>Eleanor Mae Shreffler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 20 83</b>		2b. HOUR <b>2:00AM</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 17, 1929</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS		7b. HOUR MONTHS DAYS HOURS MIN. <b>09 20 83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Georgetown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph R. Laing</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie E. Kines</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>230 30 8593</b>		17. INFORMANT ADDRESS <b>Robert E. Streffler, 12411A Hickory Tree Way</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute liver failure</b> 5711 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>alcoholic hepatitis</b> (c) <b>nutritional cirrhosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years.</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Acute pancreatitis</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <b>9/20</b> 19 <b>83</b> to <b>9/20</b> 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>9/20</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>John G. Lodmell, MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/20/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN G. LODMELL, MD</b>		22e. ADDRESS <b>1811 Prince Philip Dr Olney, MD 20832</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>09-22-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Front Royal, Warren, VA.</b>
24. FUNERAL HOME (NAME) <b>Maddox Funeral Home, Inc.</b>		ADDRESS <b>Front Royal, VA.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 27 1983</b>		
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.				24980				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEOTA Pearl SIMMONS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9 21 83</b>					2b. HOUR <b>6<sup>00</sup></b> M
3 SEX <b>Female</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 1 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD				
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Randolph Hills</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>14410 Park Vale Rd</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James - OURS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA J Judy</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>522 96 0859</b>		17. INFORMANT ADDRESS <b>Winnie L. Farr Rockville, Md. 20853</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROSIS</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>PERNICIOUS ANEMIA</b>										
19a. DATE OF OPERATION <b>8-3-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Repair Hip Fr Jewell Nail</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>10-14</b> , 19 <b>83</b> , to <b>9-7</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9-7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE OF PHYSICIAN'S NAME (TYPE OR PRINT) <b>Fred A. Gill, M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9-21-83</b>		
22e. ADDRESS <b>4743 Bradley Blvd. Chevy Chase, Md. 20015</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-24-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Weavers Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harrisonburg Virginia</b>				
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>				
23f. ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>										

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4. 17. 5. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>Wesley Simmons  |   | MONTH DAY YEAR<br>9/11/83  |   | 11:15 A.M.   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE  | 7. IF UNDER 1 YEAR   |  |
| Male   | CAUCASIAN   | MONTH DAY YEAR<br>March 11, 1924   | 59 YRS.   | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| West Virginia  | United States   |  | Montgomery County MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Bethesda   | Suburban Hospital   | Never Worked   |   |  |  |
| 13a. STATE   |   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                          |
| Maryland   | Montgomery  | Rockville  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1606 Farragut Ave Rockville, Maryland 20851  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |  |  |
| BRANSON SIMMONS  |   | ENOT KETTERMAN   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |  |  |
| NO   |   | 236-12-6152  | Patricia Chapman<br>1606 Farragut Ave Rockville, Maryland 20851     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>esophageal CA resection w/ possible metastasis</u> |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |  |   |  |  |
| COPD   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
| 8/3/83   |   | Esophageal CA  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 21</u> , 19 <u>83</u> , to <u>Sept 11</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept 11</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   | 22b. SIGNATURE<br>DEGREE   |   | 22c. DATE SIGNED   |  |
| Mary Fang, MD  |   | MD   |   | 9/11/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS   |   |  |  |
| Mary Fang, MD  |   | 11004 Roundtable Ct. Rockville MD  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |
| Burial   |   | September 5, 1983  | New Hope Cemetery   |  | Big Harp, County West Virginia               |
| 24. FUNERAL DIRECTOR<br>NAME   |   | 25a. DATE REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
| Robert A. Pumphrey, Funeral Homes PA.<br>7557 Wisconsin Ave. Bethesda, Maryland 20814  |   | SEP 19 1983  |   | John J. Connel   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 24982<br>REG. NO.  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jacob Simon</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>9-24-1983</b>  |  |   |  | 2b. HOUR<br><b>10<sup>55</sup> AM</b>  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 15 1887</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Chevy Chase R.E. Home, N.S. Center<br/>2015 East-West Highway</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector (Ret.)</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Furniture</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>14508 Homecrest Road</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Abraham Simon</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Taibel Shapiro</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | (IF YES, GIVE WAR OR DATES)<br><b>-----</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-22-7798</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Samuel W. Greenhouse; 1724 Ladd St., SSpg, Md.</b>               |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Lymphocytic Leukemia</b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Chronic Lymphocytic Leukemia</b>   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 1983</b> to <b>Sept 24 1983</b> , that (I) (we) last saw the deceased alive on <b>9-15-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Alvin I. Kay MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9-24-83</b>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALVIN I. KAY MD</b>   |  |   |  | 22e. ADDRESS<br><b>1145-19th St NW - WASH DC</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9-25-1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lebanon Mem. Park</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hyattsville, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 27 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John E. Connel</b>   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 24983  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jane Simon</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 24, 1983</b>                                    |  | 2b. HOUR<br><b>2:05pm</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 22 1923</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Purchasing Agent</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Jewish Center</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Gaithersburg</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>12 Fern Hollow Way</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Morri's Simon</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Natalie Mayer</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>174 20 3418</b>  |  | 17. INFORMANT ADDRESS<br><b>Miles Silverman-9411 Eagleton Lane</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Diabetes</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>November 21, 81</b> to <b>Sept 24, 1983</b> , that (I) (we) last saw the deceased alive on <b>Sept 24, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Jerome Schnapp, MD.</b>   |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>Sept. 24, 1983</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  | 22e. ADDRESS  |  |  |  |  |  |
| <b>Jerome Schnapp, MD.</b>   |  |  |  |   |  | <b>11161 New Hampshire Ave, Silver Spring, MD/</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Sept 27 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wash. Hebrew Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wash. D.C.</b>                                 |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ives-Pearson F. H. Falls Church, Va. 22046</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   | REG. NO.  |   |
|--|--|---|---|---|---|
| 1. FOR STATE REGISTRAR   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR                              |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Clarke W. Slade</b>   |  |   | 2b. HOUR<br><b>5:57AM</b>                                     |   |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 16, 1902</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.             | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                                      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD. |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Social Worker</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gov.</b>              |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.20860</b>   |  | 13b. COUNTY<br><b>Mont.</b>   | 13c. CITY OR TOWN<br><b>Sandy Spring</b>                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>18121 Marden Lane 20860</b> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Howard - Slade</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Carrie M. Clarke</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-32-3166</b>  |   | 17. INFORMANT ADDRESS<br><b>William M.I. Slade Silver Spring, Md.</b>                           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Sudden arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>MI</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>minutes</b> |  |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>functional Parkinson</b>  |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/28/83</b> to <b>9/29/83</b> , that (I) (we) lost saw the deceased alive on <b>9/28/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |   |   |   |   |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>9/29/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>[Signature]</b>  |  | 22e. ADDRESS<br><b>1811 P + P Highway, Olney, Md 20832</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>OCT. 1, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Cemetery</b>                                  |   |
| 23d. LOCATION CITY/TOWN COUNTY STATE<br><b>Mercersburg Franklin Penn.</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 03 1983</b>   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS H. BARBER LAYTONSVILLE, MD. 20879</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Macy K Smallwood  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9-20-83  |   | 2b. HOUR<br>1:03 AM                       |
| 3. SEX<br>Female   | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 08 26  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>57 YRS.                | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.Y.  | 7b. CITIZEN OF WHAT COUNTRY?<br>US   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD       |   |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife                   |   | 12b. KIND OF BUSINESS OR INDUSTRY         |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Anne Arundel  | 13c. CITY OR TOWN<br>Harwood   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>4748-I Flanders Lane 20776           |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Hollenbach   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Stock   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no |  | 16b. SOCIAL SECURITY NO.<br>116-18-9902  |   | 17. INFORMANT<br>ADDRESS<br>Howard K. Smallwood same as 13e |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1749 IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Adenocarcinoma of Breast

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 yrs

4 1/2 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (the hospital) attended the deceased from MAY 1979, to SEPT 20, 1983, that (I) (we) lost<br>saw the deceased alive on 9/19, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>G. Lennard Gold MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>7/20/83   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. Lennard Gold MD   |  | 22e. ADDRESS<br>8630 Fenton St., Silver Spring, Md.  |   |

|   |                            |   |   |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation | 23b. DATE<br>Sept. 23 1983 | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Crematory | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood, Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Beall Funeral Home        |                            | 25a. DATE REC'D. BY REGISTRAR<br>SEP 21 1983                | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 24986  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Dorothy Jane SMITH</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Sept. 12, 1983</b>   |  | 2b. HOUR<br><b>9:08 AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 17, 1942</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>40</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co., MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13e. STREET ADDRESS   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13d. CITY OR TOWN<br><b>Gaithersburg</b>  |  | 13e. STREET ADDRESS<br><b>7901 Spiceberry Circle, Apt. 3</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Otis L. Kline</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Edith Reynolds</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>213-46-7244</b>   |  | 17. INFORMANT ADDRESS<br><b>Coy Larkin Smith, Item 13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest with CPR</b><br><b>2800</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypotension, Left Large pleural Effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe Iron Deficiency Anemia</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Aug. 31</b> , 19 <b>83</b> , to <b>Sept. 12</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Sept. 12</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Samuel W. Chang, M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9-12-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel W. Chang, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>20100 Fisher Ave., Poolesville, Md. 20837</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Sept. 15, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethesda Meth.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Browningsville, Montg., Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Orin L. Molesworth, P.A., Damascus, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>SEP 19 1983 [Signature]</b>  |  |   |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                       |   |   |  |   | 24987  |  |
|---|-----------------------|---|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                       |   |   |  |   | REG. NO.   |  |
| <b>I. DECEASED NAME</b><br>(TYPE OR PRINT) <span style="float: right;"><b>FIRST</b></span> <span style="float: right;"><b>MIDDLE</b></span> <span style="float: right;"><b>LAST</b></span><br><div style="clear: both;"></div> Edward M. Smith  |                       |   |   |  |   | <b>2a. DATE KNOWN OF DEATH</b><br>ESTIMATED Sept 20 1983   |  |
| <b>3. SEX</b><br>M  | <b>4. RACE</b><br>Blk | <b>5. DATE OF BIRTH</b><br>MONTH DAY YEAR<br>May 4 1944   | <b>6. AGE (IN YEARS)</b><br>(LAST BIRTHDAY)<br>YRS.<br>39 | <b>IF UNDER 1 YR.</b><br>MONTHS DAYS HOURS MIN   | <b>IF UNDER 24 HRS.</b><br>HOURS MIN  | <b>2c. DATE PRONOUNCED DEAD</b><br>Sept 21 1983  |  |
| <b>7a. BIRTHPLACE</b> (STATE OR FOREIGN COUNTRY)<br>Goochland, Va.  |                       | <b>7b. CITIZEN OF WHAT COUNTRY?</b><br>USA  |   | <b>8. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | <b>9. BALTIMORE CITY OR COUNTY OF DEATH</b><br>Montgomery MD   |  |
| <b>10. CITY OR TOWN OF DEATH</b><br>St. Leger   |                       | <b>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION</b><br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wolf Creek Hosp. |   |  | <b>12a. USUAL OCCUPATION</b> (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer Operator | <b>12b. KIND OF BUSINESS OR INDUSTRY</b><br>Private  |  |
| <b>USUAL RESIDENCE</b> (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>13a. STATE</b><br>Md.   |                       |   |   | <b>13b. COUNTY</b><br>Mont   | <b>13c. CITY OR TOWN</b><br>St. Leger   | <b>13d. INSIDE CITY LIMITS?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>14. FATHER'S NAME</b><br>FIRST MIDDLE LAST<br>Julius Smith   |                       |   |   | <b>15. MOTHER'S MAIDEN NAME</b><br>FIRST MIDDLE LAST<br>Bertie Unknown   |   |  |  |
| <b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(YES, NO, OR UNKNOWN)<br>No  |                       |   | <b>16b. SOCIAL SECURITY NO.</b><br>578-26-7641            |  | <b>17. INFORMANT</b><br>ADDRESS Mrs. Angie Smith 8802 Lanier Dr. Sil. Sdg.                |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br><b>PART I DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) Acute Myocardial Infarction<br>4291 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |                       |   |   |  |   |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  |
| <b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).</b><br>None  |                       |   |   |  |   |  |  |
| <b>19a. DATE OF OPERATION</b><br>None   |                       | <b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b>  |   |  |   |  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| <b>21a. EXTERNAL CAUSE WAS</b><br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                       | <b>21b. TIME OF INJURY</b><br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | <b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |
| <b>21d. INJURY OCCURRED</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                       | <b>21e. PLACE OF INJURY</b> (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | <b>21f. LOCATION</b><br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| <b>22a. I certify that I took charge of the remains described above, held on death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                       |   |   |  |   |  |  |
| <b>ACTUAL SIGNATURE</b><br>   |                       |   |   | <b>TITLE (SPECIFY)</b><br>M.D. Dep.  |   | <b>MEDICAL EXAMINER</b><br>DATE SIGNED Sept 20, 1983   |  |
| <b>EXAMINER'S NAME</b> (TYPE OR PRINT) ADDRESS  |                       |   |   |  |   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (SPECIFY)<br>Burial  |                       | <b>23b. DATE</b><br>Sept/23/83  |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>Rock Creek Cemetery   |   | <b>23d. LOCATION</b><br>CITY OR TOWN COUNTY STATE<br>Washington D.C.                                   |  |
| <b>24. FUNERAL DIRECTOR</b><br>NAME R.W. Horton Co. Mort. Inc. ADDRESS 600 Kennedy St. WASHINGTON, D.C.   |                       |   |   | <b>25a. DATE REC'D. BY REGISTRAR</b><br>SEP 27 1983  |   | <b>25b. REGISTRAR'S SIGNATURE</b><br>  |  |



93819-10110

UNITED STATES

NAVY



Released to NIA autopsy

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

|  |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |  | 24788  |  |
| 1- FOR STATE REGISTRAR   |  |  |   |  |  |  |  |  |  | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>June Edith Smith</b>   |  |  | 2. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>9-29 83</b>  |  |  | 3. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-29 83</b>   |  |  | 4. HOUR<br>P M<br><b>3:00</b>  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 8 19 64</b>   |  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>19 YRS.</b>  |  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS<br><b>19</b>  |  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>19</b>                                       |  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>   |  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                           |  |  |
| 13. CITY OR TOWN OF DEATH<br><b>Beth, Md</b>   |  |  | 14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>United Inn of Am</b> |  |  | 15. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  |  | 16. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  |  |
| 17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE<br><b>Kentucky</b>  |  |  | 17b. COUNTY<br><b>Christian</b>   |  |  | 17c. CITY OR TOWN<br><b>Hopkinsville</b>   |  |  | 17d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jimmy Smith</b>   |  |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lena Smith</b>  |  |  | 20. STREET ADDRESS<br><b>Rt. 6</b>   |  |  | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>  |  |  | 23. SOCIAL SECURITY NO.<br><b>401-22-2584</b>   |  |  | 24. INFORMANT<br><b>Mrs. Nancy Croley 2nd cousin</b>   |  |  | 25. ADDRESS<br><b>Mr. Everett C. Huckeby 1st cousin, same</b>                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4140 Cardiac arrest.</b><br>IMMEDIATE CAUSE (a).<br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(b) Coronary arteriosclerosis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(c)</b>   |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Carcinoma of ovary.</b>  |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |   |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John Tauber</b>   |  |  | M.D.<br><b>John Tauber</b>  |  |  | MEDICAL EXAMINER<br><b>Bethesda</b>  |  |  | DATE SIGNED<br><b>9-29-83.</b>   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John Tauber</b>   |  |  | ADDRESS<br><b>8218 Wisconsin Ave</b>  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>10-3-83</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Riverside Cemetery</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hopkinsville, Ky.</b>               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marshall's Funeral Home</b>   |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>4217 9th Street NW: Washington, D.C.</b>   |  |  | 26. REGISTRAR'S SIGNATURE<br><b>John J. Gurnea</b>   |  |  |  |  |  |

BP  
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VR A15 ME (51)  
20M 4/82

FROM FIBER



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Katherine Dennis Smith  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9/7/83  |  |  |  |
| 3. SEX<br>Female   |  |  |  | 4. RACE<br>Cauc.   |  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 24, 1893   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Chevy Chase   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bethesda Retirement & Nsg. Cntr.  |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.  |  |  |  |
| 13a. STATE<br>D.C.   |  |  |  | 13b. COUNTY<br>Washington  |  |  |  |
| 13c. CITY OR TOWN<br>Washington  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13e. STREET ADDRESS<br>1789 Lanier Pl. NW 20010  |  |  |  | 13f. STREET ADDRESS<br>1789 Lanier Pl. NW 20010  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harold Dale Dennis   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jennie Manlove  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>Unk.   |  |  |  |
| 17. INFORMANT<br>James C. Toomey   |  |  |  | 17b. ADDRESS<br>4708 Wisconsin Ave. NW<br>Washington, D.C.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one condition on line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma Cervical<br>1809<br>DUE TO OR AS A CONSEQUENCE OF<br>(b) Squamous Cell Carcinoma<br>DUE TO OR AS A CONSEQUENCE OF<br>(c) Squamous Cell Carcinoma<br>8 months |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>8 months  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |  |  |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 9/7/83 to 9/7/83, that (1) (we) lost<br>saw the deceased alive on 9/7/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) (did not) view the body after death.                       |  |  |  | 22b. SIGNATURE<br>J. D. Toomey<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |
| 22c. DATE SIGNED<br>9/7/83   |  |  |  | 22d. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |  |  | 23b. DATE<br>9/8/1983  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Columbia Mortuary Services, Inc.<br>225 Missouri Ave. NW Washington, D.C. 20011  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>SEP 13 1983  |  |  |  |
| 26. REGISTRAR'S SIGNATURE<br>B. J. Carver  |  |  |  |  |  |  |  |

325 Missouri Ave. NW Washington, D.C. 20011  
Columbia Laundry Service, Inc.  
Leeds Crumery 4/8/1983

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |   |                                  |  |   |   |  |  |
|--|--|--|---|---|----------------------------------|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PAULINE Virginia SMITH              |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9/2/83 |   |                                  | 2b. HOUR<br>830/A M  |   |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 30 03  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                    |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist Hospital |   |   |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supply Clerk |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Supplies |  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Montgomery                     |   | 13c. CITY OR TOWN<br>Takoma Park |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>6 Philadelphia Avenue 20012 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Wagener                   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Elizabeth Whitmer  |                                  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |   | 17. INFORMANT<br>8501 Gibbons Drive<br>Warren A. Smith Fort Washington, Maryland  |                                  |  |   |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) Breast Cancer.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/83, 19, to 9/2/83, 19 83, that (I) (we) last saw the deceased alive on 9/1/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>SMITH HO, M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SMITH HO, M.D.  |  |  |  | 22e. ADDRESS<br>8323 Haddon DR. Takoma PK Md. 20912  |  |   |  |

|  |  |                                |  |   |  |  |  |
|--|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>September 6, 1983 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Pr. Geo., Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lee Funeral Home, Inc. |  |                                |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 6 1983               |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith                                |  |
| Old Alexander Ferry Road, Clinton, Maryland            |  |                                |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 24991  |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THELMA TILLOTSON SMITH</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 15 1983</b>   |  |   |  | 2b. HOUR<br><b>11:50 P</b>  |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 13 1927</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>MIN.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BUDGET ANALYST</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S.GOV'T.</b>  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>9600 BRUCE DRIVE 20901</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERBERT NOBLE TILLOTSON</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ONEITA LILLIAN JOHNSON</b>  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>  |  | 17. INFORMANT ADDRESS<br><b>THOMAS R. SMITH, 9600 BRUCE DRIVE,</b>  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>1537</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ADENOCARCINOMA OF THE COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 29</b> , 19 <b>83</b> , to <b>SEPTEMBER 15</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 15</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Michael D. Canty</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>16 Sept 83</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL D. CANTY, LT. MC, USNR</b>   |  |  |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,<br/>NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>SEP. 17 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>METROPOLITAN CREMATORY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ALEXANDRIA VIRGINIA</b>                        |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>SEP 19 1983</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Collins</b>  |  |   |  |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.  |  |  |  |   |  |   |  |   |  |   |  |

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RECEIVED  
FEBRUARY 1964  
U.S. DEPARTMENT OF AGRICULTURE

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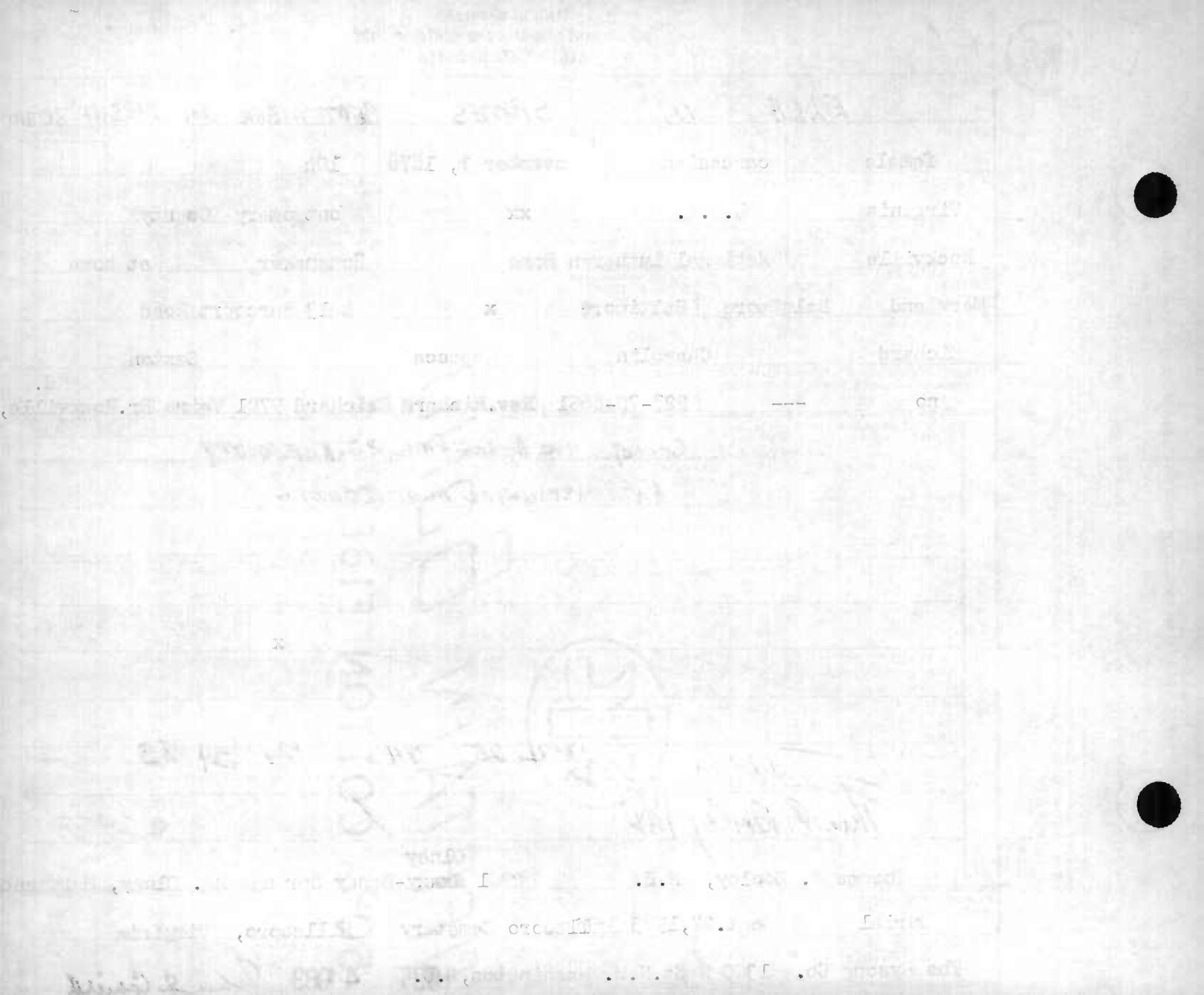
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLA M. SPATES</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 24, 1983</b>                           |   | 2b. HOUR <b>4:30pm</b>   |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 2, 1878</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>104</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                 |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Lutheran Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4413 Harcourt Road</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard Chamblin</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Sexton</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>227-70-8651</b>  |  | 17. INFORMANT ADDRESS<br><b>Rev. Richard Reichard 9701 Veirs Dr. Rockville, Md.</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4140 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE, REFRACTORY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTEROSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>APRIL 25, 1974</b> , to <b>Sept 24, 1983</b> , that (I) (we) last saw the deceased alive on <b>Sept 23, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Thomas E. Dooley, M.D.</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>9/24/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas E. Dooley, M.D.</b>   |  | 22e. ADDRESS<br><b>Olney 2901 Sandy-Sandy Springs Rd. Olney, Maryland</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Sept. 27, 1983</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillsboro Cemetery</b>                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hillsboro, Virginia</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>The Hysong Co.</b>  |  | ADDRESS<br><b>1300 N St. N.W. Washington, D.C.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>4 1983</b><br>25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b> |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |                                  |  |  |   |  |   |          | REG. NO.  |  |
|---|--|--|----------------------------------|--|--|---|--|---|----------|---|--|
| 1. FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME (TYPE OR PRINT) |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   | 2b. HOUR |   |  |
|   |  |  | John T. Spicknall, Sr.           |  |  | September 23, 1983  |  |   | 2110 M   |   |  |
| 3. SEX  |  | 4. RACE  |                                  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |          | IF UNDER 24 HRS   |  |
| Male  |  | Caucasian  |                                  | July 14, 1895  |  | 88  |  | MONTHS DAYS   |          | HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |          |   |  |
| Maryland  |  | United States  |                                  |  |  | Montgomery County MD  |  |   |          |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |          |   |  |
| Rockville   |  | Shady Grove Adventist Hosp.  |                                  |  |  | Minister  |  | Ministry  |          |   |  |
| 13a. STATE  |  |  |                                  |  |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |          | 13d. STREET ADDRESS   |  |
| Maryland  |  |  |                                  |  |  | Montgomery  |  | Gaithersburg  |          | 401 Russell Avenue  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |                                  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |          |   |  |
| Jay J. T. Spicknall   |  |  |                                  |  |  | Not Available   |  |   |          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR & DATES)  |  |  |                                  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (Son)   |  | ADDRESS 22 Concord Ave.   |          |   |  |
| Yes WW I  |  |  |                                  | 220-34-0435  |  | John T. Spicknall Jr, Metuchen, NJ  |  |   |          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL ARREST (SUDDEN CARDIAL DEATH)</u>  |  |  |                                  |  |  |   |  |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |                                  |  |  |   |  |   |          | DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> |  |
|   |  |  |                                  |  |  |   |  |   |          | DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 YRS</u>                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PAST MYOCARDIAL INFARCTS; BRADYARRHYTHMIAS - CARDIAC PACEMAKER</u>  |  |  |                                  |  |  |   |  |   |          |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |          |   |  |
| N/A   |  | N/A  |                                  |  |  |   |  |   |          |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |          |   |  |
|   |  | 19   |                                  |  |  |   |  |   |          |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |          |   |  |
|   |  |  |                                  |  |  |   |  |   |          |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>JAN</u> , 19 <u>80</u> to <u>9/9</u> , 19 <u>83</u> , that (we) lost saw the deceased alive on <u>9/9</u> , 19 <u>83</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death. |  |  |                                  |  |  |   |  |   |          |   |  |
| 22b. SIGNATURE  |  |  |                                  |  |  | DEGREE  |  | 22c. DATE SIGNED  |          |   |  |
| <u>Alan N. Schulman</u>   |  |  |                                  |  |  |   |  | 9/24  |          |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |                                  |  |  | 22e. ADDRESS  |  |   |          |   |  |
| ALAN N. SCHULMAN, MD  |  |  |                                  |  |  | 9715 MEDICAL CENTER DRIVE ROCKVILLE, MD. 20850                                    |  |   |          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |                                  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |          |   |  |
| Burial  |  | 27, 1983   |                                  | Woodlawn Cemetery  |  | Baltimore   |  | Maryland  |          |   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |                                  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |          |   |  |
| Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland   |  |  |                                  |  |  | SEP 28 1983   |  | <u>John J. Conner</u>   |          |   |  |

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1. The first part of the report is a summary of the work done during the year. It covers the period from January 1 to December 31, 1963. The summary is divided into two main sections: a general summary and a summary of the work done in each of the four major areas of research.

2. The general summary is divided into three parts: a description of the work done, a description of the results obtained, and a description of the conclusions reached. The summary of the work done in each of the four major areas of research is also divided into three parts: a description of the work done, a description of the results obtained, and a description of the conclusions reached.

3. The results obtained during the year are described in detail in the following sections. The first section describes the results obtained in the study of the properties of the new material. The second section describes the results obtained in the study of the properties of the new material. The third section describes the results obtained in the study of the properties of the new material.

4. The conclusions reached during the year are described in detail in the following sections. The first section describes the conclusions reached in the study of the properties of the new material. The second section describes the conclusions reached in the study of the properties of the new material. The third section describes the conclusions reached in the study of the properties of the new material.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEFA JAZMIN STAMATELAKY</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 11 1983</b>  |  |   |  |
| 3. SEX <b>FEMALE</b>   |  |  |  | 2b. HOUR <b>6:34 p.m.</b>  |  |   |  |
| 4. RACE <b>MALAYSIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 5 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PHILIPPINES</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.   |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>  |  |   |  |
| 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>HOWARD</b> 13c. CITY OR TOWN <b>COLUMBIA</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>EULALIO JAZMIN</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JARARD JAZARANO</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>214-76-9717</b>  |  | 17. INFORMANT ADDRESS <b>ALEXANDER STAMATELAKY, 2308 OLD COMPTON RD.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7991</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 24</b> , 19 <b>83</b> , to <b>SEPTEMBER 11</b> , 19 <b>83</b> , that (I) (we) lost <b>saw the deceased alive on SEPTEMBER 11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) visit the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Michael D. Canty</b>   |  | DEGREE <b>MO</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>7/12/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL D. CANTY, LT, MC, USNR</b>  |  | 22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>                       |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>SEPT 15, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BURTONSVILLE, MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>DONALDSON FUNERAL HOME, LAUREL, MD</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>2. Caniel</b>   |  |



RECEIVED  
SEP 12 1964  
U.S. AIR FORCE

RECEIVED  
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1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |                                   |  |
|--|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH   |  | MONTH YEAR  |  | 2b. HOUR                          |  |
| Kazimierz (NMI) Stanczak   |  |   |  | September 21, 1983  |  |   |  | 1:30 P.M.                         |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                   |  |
| Male   |  | Caucasian   |  | October 4, 1921   |  | 61 YRS.   |  | IF UNDER 24 HRS                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |  |
| Poland   |  | United States   |  |   |  | Montgomery County, MD.  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                   |  |
| Wheaton  |  | University Nursing Home   |  | Plasterer   |  | Construction  |  |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?          |  |
| Maryland   |  | Montgomery  |  | Bethesda  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS               |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                     |  |
| Franciszek   |  | Jozefa  |  | No  |  | 579-40 -7749  |  | Olga G. Stanczak wife same as 13e |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Transition</u><br>3429<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Cytophagia &amp; aspiration</u><br>(c) <u>Severe BPT Hemiparesis</u>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 month</u><br><u>1 week</u><br><u>3 months</u>        |  |   |  |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Chronic obstructive pulmonary disease</u>   |  |   |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 19c. AUTOPSY?   |  | 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                   |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>September 9-16</u> 19 <u>83</u> , to <u>9-21</u> 19 <u>83</u> , that (I) <u>was</u> last saw the deceased alive on <u>9-16</u> 19 <u>83</u> and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Jason Geiger</u><br>DEGREE   |  | 22c. DATE SIGNED<br>Sept. 21, 1983  |  |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jason Geiger, M.D.  |  | 22e. ADDRESS<br>8830 Cameron Street<br>Silver Spring, Maryland 20910                                      |  |   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>Sept. 23, 1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria Virginia   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes,<br>P.A., Bethesda, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 26 1983  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>  |  |   |  |                                   |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

BP

[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

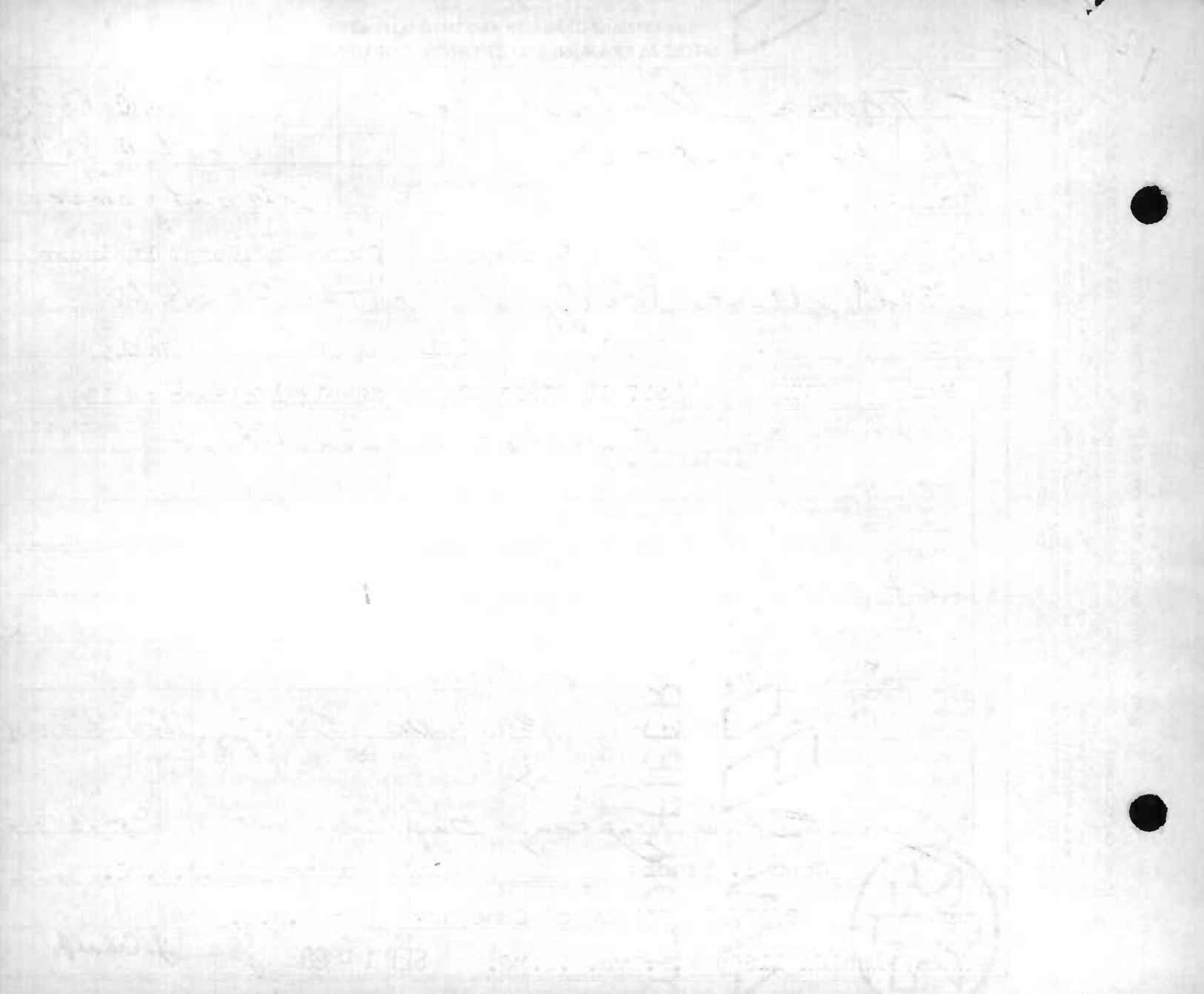
FOR  
- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24996

REG. NO.

|  |                     |  |   |   |  |  |   |  |  |
|--|---------------------|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Thomas Walton Steel</b>   |                     |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR <b>Sept 10 1983</b>       |   |  | 2b. HOUR<br>MIN <b>7:30</b>  |   |  |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Aug 25 1969</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>14</b>                   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>Sept 10 1983</b>                           | 2d. HOUR<br>MIN <b>7:30</b>  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash.D.C.</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Sil Spg</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>521 Blick Dr.</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Stone Ind. Corp.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Engineer</b>                                |  |  |
| 13a. STATE<br><b>MD.</b>   |                     | 13b. COUNTY<br><b>Mont.</b>  |   | 13c. CITY OR TOWN<br><b>Sil Spg</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>521 Blick Dr.</b> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James R. Steel</b>  |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Lusby</b> |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |                     | 16b. SOCIAL SECURITY NO.<br><b>WWII</b>  |   | 17. INFORMANT ADDRESS<br><b>577 10 4235A Gladys Steel (Wife) Same as 13c</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound Chest</b><br>9554<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                     |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |                     |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>7:30 P.M. 9 10 1983</b>   |                     | 21b. TIME OF INJURY<br>HOUR MIN MONTH DAY YEAR<br><b>7:30 P.M. 9 10 1983</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Shot Self</b>   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>140ma</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Blick Dr. Sil Spg. Mont. Md</b>   |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                     |  |   |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>  |                     | TITLE (SPECIFY)<br><b>M.D.</b>   |   | MEDICAL EXAMINER<br><b>John S. Rogers</b>   |  | DATE SIGNED<br><b>Sept 10 1983</b>   |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John S. Rogers</b>  |                     | ADDRESS<br><b>1919 Seminary Rd. S.S.Md.</b>  |   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                     | 23b. DATE<br><b>9/13/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wash.D.C.</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hines/Rinaldi 11800 N.H.Ave.S.S.Md.</b>   |                     |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carter</b>  |   |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Norman

J.

Stritter

2a. DATE OF DEATH

MONTH

DAY

YEAR

September 18, 1983

2b. HOUR

6:10 AM

3 SEX

Male

4 RACE

Caucasian

5 DATE OF BIRTH

MONTH DAY YEAR

February 22, 1901

6 AGE (IN YEARS LAST BIRTHDAY)

82

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN.

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

New York

7b. CITIZEN OF WHAT COUNTRY?

United States

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County, MD

10 CITY OR TOWN OF DEATH

Wheaton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

University Nursing Home

12a. USUAL OCCUPATION

(TYPE OF WORK OR MOST OF WORKING LIFE)

Sorter

12b. KIND OF BUSINESS OR INDUSTRY

U.S. Post Office

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Rockville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

16413 Deer Lake Rd. (20855)

14. FATHER'S NAME

FIRST

John

MIDDLE

LAST

Stritter

15. MOTHER'S MAIDEN NAME

FIRST

Hattie

MIDDLE

LAST

Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

WWI

090-22-4074

17 INFORMANT

ADDRESS

Barbara Stanton, Niece, Same as item #13

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

1919

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from 9-15, 1983, to 9-18, 1983, that (1) (we) last saw the deceased alive on 9-12, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not see the body after death)

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

Sept. 18, 1983

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

W. Goosch, MD

22e. ADDRESS

2309 Shorefield Dr. Wheaton, Md 20902

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Sept. 22, 1983

23c. NAME OF CEMETERY OR CREMATORY

Woodlawn Memory Gardens Seminole

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Florida

24. FUNERAL DIRECTOR NAME

Robert A. Pumphrey Funeral Homes,

P.A. Rockville, Maryland

25a. DATE REC'D. BY REGISTRAR

SEP 22 1983

25b. REGISTRAR'S SIGNATURE

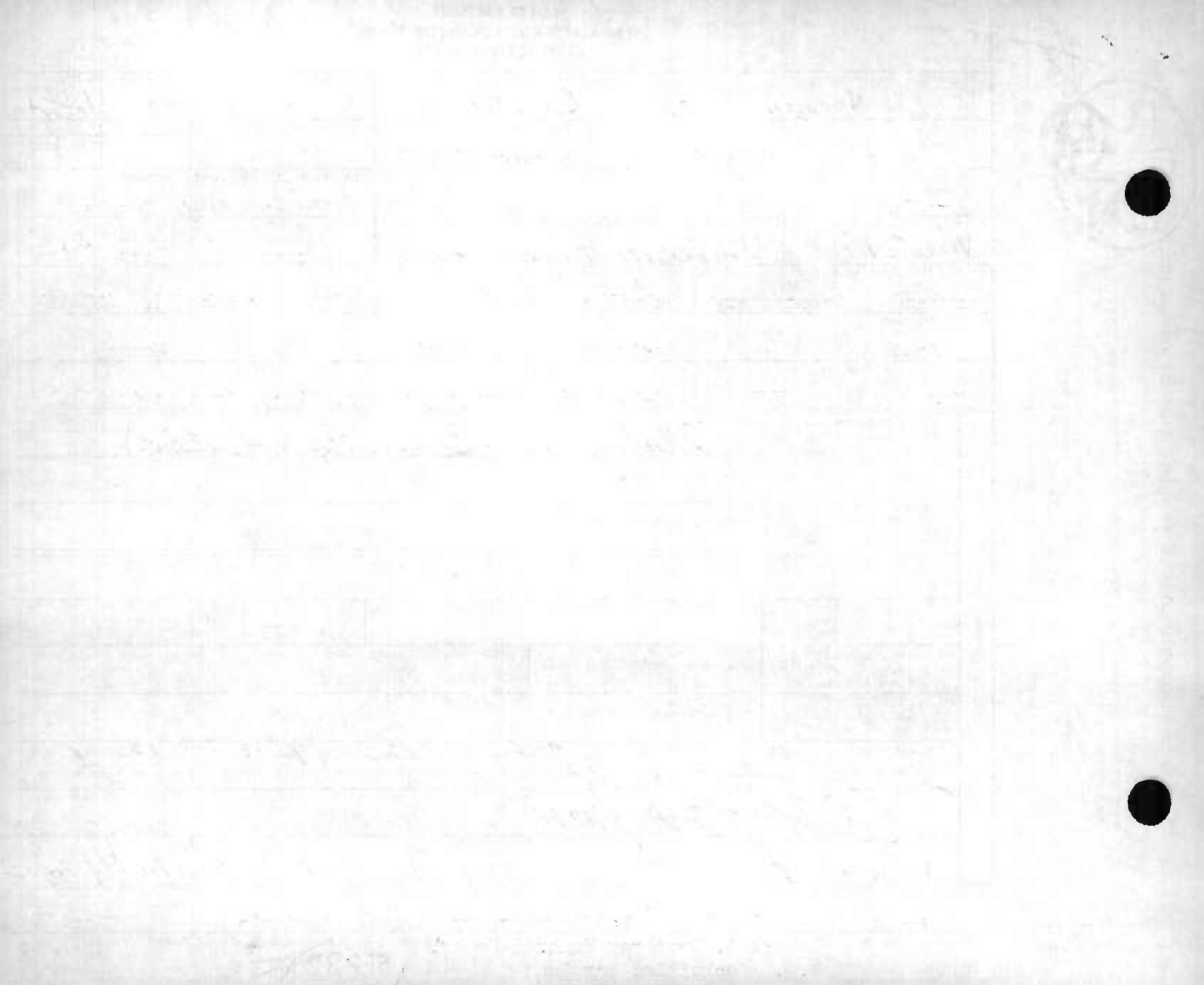
John J. Canine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |  |  | REG. NO.  |  |
|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |   |  | 2. DATE OF DEATH MONTH DAY YEAR                              |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>George B. Swift   |   |  | 2b. HOUR MIN. 9:18:51 P.M.                                   |   |  |
| 3. SEX<br>male  | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11:12:02 80   | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.                      |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |   |  |
| 9. CITY OR TOWN OF DEATH<br>Silver Spring   | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital | 11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OR INDUSTRY<br>Chicago Daily News |  |   |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>MD. Montgomery Silver Spring   | 14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  | 15. STREET ADDRESS 2102 Randolph Rd. Silver Spring MD. 20902                                   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GEORGE A. SWIFT  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CHARLOTTE SPRY |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |   |  | 16b. SOCIAL SECURITY NO. 347-03-0732                         |   |  |
| 17. INFORMANT ADDRESS 3203 Parkview Road  |   |  | 18. RICHARD SWIFT, SON, Chevy Chase, Md. 20815               |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) LUNG CANCER<br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/16/83 to 9/18/83, that (I) (we) lost saw the deceased alive on 9/16/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |   |  |  |   |  |
| 22b. SIGNATURE AMIEL SEGAL  |   |  |  | 22c. DATE SIGNED 9/16/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMIEL SEGAL   |   |  |  | 22e. ADDRESS 2201 L ST NW DC  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |   | 23b. DATE Sept. 20, 1983   |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland P. G. Cty., Maryland |  |
| 24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO., 8655 Ga., Ave., SS, Md. 20910  |   | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983  |  | 25b. REGISTRAR'S SIGNATURE  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Ladislau Szalay  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 7, 1983  |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>January 30, 1899   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Hungary   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Argentina  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Potomac  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10517 Mac Arthur Blvd. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Private   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Potomac  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS Zip: 20854<br>10517 MacArthur Blvd   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Szalay  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Paula Trishler  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO<br>N/A   |  | 17 INFORMANT (Wife)<br>Ilona Szalay, Blvd, Potomac, MD   |  | ADDRESS 10517 MacArthur  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY<br>1850 IMMEDIATE CAUSE (a) Metastatic Carcinoma<br>DUE TO, OR AS, CONSEQUENCE OF<br>(b) Carcinoma Prostate<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years<br>3+ yrs  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 8, 1980, to Sept 7, 1983, that (I) (we) lost the deceased alive on Aug 31, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>George I. Mishtowt, MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>Sept 7-83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George I. Mishtowt  |  |  |  | 22e. ADDRESS<br>5454 Wisconsin Ave, Chevy Chase, MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>September 8, 1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Alexandria Virginia   |  |
| 24 FUNERAL DIRECTOR NAME<br>Robert A. Pumphrey<br>Homes, P.A., Bethesda, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 13 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. [Signature]  |  |

BP

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*[Faint, illegible handwriting and markings across the page, possibly bleed-through from the reverse side.]*

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25000

|   |   |   |   |   |
|---|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>RUTH G. TARANTINO</b>  |   | 2a. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>17</b> Year <b>1983</b>  |   | 2b. HOUR<br><b>8:42 PM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br><b>Aug. 3 1912</b>  | 6. AGE (In years lost birthday)<br><b>71</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>71</b> DAYS <b>71</b>  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Montgomery</b>           |   |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>4801 Langdrum Lane</b>   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland 20815</b>  |   | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>           | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                           |
| 14. FATHER'S NAME First <b>Edgar</b> Middle <b>Gagnon</b> Last <b>Poquette</b>  |   | 15. MOTHER'S MAIDEN NAME First <b>Katherine</b> Middle <b>Poquette</b> Last <b>Poquette</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215-54-9842</b>  |   | 17. INFORMANT<br><b>Arthur E. Tarantino Same as item 13.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C. V. A.</b><br>4360 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b> |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/><br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12 Sept 1982</b> , to <b>17 Sept 1983</b> , that (I) (we) last saw the deceased alive on <b>12 Sept 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |   |   |   |   |
| 22b. SIGNATURE<br><b>JEFFREY J. DAUM</b>  |   | 22c. DATE SIGNED<br><b>17 Sept 83</b>   |   | 22d. ADDRESS<br><b>7505 DEMOCRACY BLVD BETHESDA MD</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE<br><b>9/20/1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Silver Spring, Maryland.</b>  |   | 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons Inc. 5130 Wisc. Ave., Wash., D.C.</b>   |   |   |
| 25a. REC'D BY REGISTRAR<br><b>SEP 22 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |   |   |

Wash., D.C.

1917

April 10, 1917

Dear Sir:

Enclosed

X

Very truly yours,

...

Respectfully,

Very

Respectfully,

Very truly yours,

Respectfully,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours, ...

o

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |                                     |   |  |  |   |  |
|---|--|--|--|--|-------------------------------------|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jessica H. Tattersall</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 9, 1983</b> |  |                                     | 2b HOUR<br><b>5:00A M</b>   |  |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 26, 1919</b>  |                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Scotland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                 |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Derwood</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7216 Blanchard Drive</b> |  |  |                                     | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>            |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b> |  |  | 13b COUNTY<br><b>Montgomery</b>                                |  | 13c. CITY OR TOWN<br><b>Derwood</b> |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>7216 Blanchard Drive 20855</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Hutcherson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary McMeanemy</b>   |                                     |   |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>            |  |  |  | 16b SOCIAL SECURITY NO.<br><b>113 10 6635</b>  |                                     | 17. INFORMANT<br>ADDRESS<br><b>Joan E. Crowe Daughter Same as 13e</b>               |  |  |   |  |

|  |  |   |  |
|--|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>4148<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>recent CVA</b>  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I <input checked="" type="checkbox"/> hospital) attended the deceased from <b>July 19 83</b> to <b>Sept. 9 19 83</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>Aug. 20 19 83</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> did not view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Gary H. Miller MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Sept. 9, 1983</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary H. Miller</b>   |  |  |  | 22e. ADDRESS<br><b>1601 18th St. NW, Washington, D.C. 20009</b>  |  |   |  |

|   |  |                                    |  |  |  |   |  |
|---|--|------------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Sept. 12, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Boca Raton Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Boca Raton Florida</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Pumphrey Funeral Homes,<br/>P.A., Rockville, Maryland</b> |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1983</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                     |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
|--|--|--|--|--|--|---|--|---------------------------|--|--------------------------------|--|-----------------------|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH         |  | MONTH                          |  | DAY                   |  | YEAR   |  | 2b. HOUR |  |
| GEORGE P TAYLOR  |  |  |  |  |  |   |  | 9/27/83                   |  |                                |  |                       |  |  |  | 2 A.M.   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR           |  | IF UNDER 74 HRS                |  |                       |  |  |  |          |  |
| MALE   |  | CAUCASIAN  |  | SEPT. 30 1908  |  | 74 YRS.   |  | MONTHS                    |  | DAYS                           |  | HOURS                 |  | MIN.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                           |  |                                |  |                       |  |  |  |          |  |
| WASHINGTON, D.C.   |  | U.S.A.   |  |  |  | MONTGOMERY MD.  |  |                           |  |                                |  |                       |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                           |  |                                |  |                       |  |  |  |          |  |
| SILVER SPRING  |  | CARRIAGE HILL NURSING HOME   |  | IRON WORKER  |  | PRIVATE IND.  |  |                           |  |                                |  |                       |  |  |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS            |  |                       |  |  |  |          |  |
| MARYLAND   |  | MONTGOMERY   |  | SILVER SPRING  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2218 Luzerne Avenue 20910 |  |                                |  |                       |  |  |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| George W. Taylor   |  | Bertha Jenkins   |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                           |  |                                |  |                       |  |  |  |          |  |
| Yes  |  | WWII   |  | 578-10-7560  |  | George F. Daly  |  | Nephew                    |  | 12923 Sutters Lane             |  | Bowie, Maryland 20715 |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  | 4860   |  | pneumonia - rt lung  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | (b)                       |  | DUE TO, OR AS A CONSEQUENCE OF |  | (c)                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | 10 days  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last.  |  |  |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  | stroke syndrome & resid aphasia - ASHD & Hx M.I.   |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                           |  |                                |  |                       |  |  |  |          |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                           |  |                                |  |                       |  |  |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  | P.M. 19  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY                    |  | STATE                          |  |                       |  |  |  |          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 65 to 9-27, 19 83, that (I) (we) lost view the deceased alive on 9-20, 19 83, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |                           |  |                                |  |                       |  |  |  |          |  |
|  |  | George F. Sengstack, M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 9-27-83   |  |                           |  |                                |  |                       |  |  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| George F. Sengstack, M.D.  |  | 9241 Columbia Blvd. Silver Spring, Md.   |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN              |  | COUNTY                         |  | STATE                 |  |  |  |          |  |
| Burial   |  | Sep. 29, 1983  |  | Mt. Olivet Cemetery  |  | Washington, D.C.  |  |                           |  |                                |  |                       |  |  |  |          |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| Francis J. Collins   |  | OCT 3 1983   |  | John J. Conner   |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |
| 500 University Blvd. W. Silver Spring, Md.   |  |  |  |  |  |   |  |                           |  |                                |  |                       |  |  |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health department within 24 hours after death.

IMPORTANT: If item 21 is marked or item 25 shows any injury, or other traumatic event, the medical examiner must be notified.

9/2/24

TAYLOR

GEORGE

CARLAGE WILL MURRING HOME

10/2/24 - 10/2/24 - 10/2/24

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25003

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Elizabeth L. THOMAS</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9 17 83</i> |   |  | 3b. HOUR<br><i>4:43P</i>  |  |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Black</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>June 24, 1915</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><i>None</i>           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington, D.C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Mont</i> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Maryland</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>        |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>D. C.</i> |  | 13b. COUNTY<br><i>Washington</i>   |   | 13c. CITY OR TOWN<br><i>Washington</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>1110 Aspen St. N.W. 99999</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Ralph Davis</i>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Rebecca Zilks</i>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>None</i>                                  |  | 16b. SOCIAL SECURITY NO.<br><i>577-34-9564</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>Ms. Evelyn Macon/sister/1004 Upshur St. N.E.</i>   |  |   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>4264 Ventricular Fibrillation</i><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cardiomyopathy</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1; or  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>8/24 9/17 83</i> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>9801 GEORGIA AVE Silver Spring Md</i>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/24 83</i> to <i>9/17 83</i> , that (I) (we) last saw the deceased alive on <i>8/24 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Mark H. Ellis</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>9/18/83</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Mark H. Ellis</i>  |  | 22e. ADDRESS<br><i>9801 GEORGIA AVE Silver Spring Md</i>               |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><i>Burial</i>  |  | 23b. DATE<br><i>9-23-83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lincoln Memorial</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Suitland, Md.</i>   |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John T. Rhines Co., 3015 12th St. N.E. D.C. 20002</i> |  | 25a. DATE REC'D. BY REGISTRAR<br><i>SEP 22 1983</i> |  | REGISTRAR'S SIGNATURE<br><i>John J. Gough</i> |  |
|--|--|---|--|---|--|



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |   |  |  |   |  |
|--|--|---|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR                                    |   |   | 2b. HOUR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary V. Thomas   |  |   | September 2, 1983   |   |   | 6:15A <sub>M</sub>   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 24, 1917   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>66   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY CO., MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.  |  |   | 13b. CITY OR TOWN<br>Montg.   |   | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>13901 Castle Blvd 20904                       |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Samuel T. Bacon   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Hester M. Fuller  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br>Harold Thomas, Sr. (Husband) same as #13                 |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal Failure</u><br><u>5860</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>DIABETES Mellitus, Gangrene</u>   |  |   |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><u>July 28, 1983</u>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Gangrene</u> |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 26</u> , 19 <u>83</u> , to <u>September 2</u> , 19 <u>83</u> , that (I) <del>was</del> lost saw the deceased alive on <u>September 1</u> , 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death. |  |   |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Barry Beers</u>   |  |   | DEGREE<br><u>M.D.</u>   |   |   | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>9/2/83</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Raymond Bass  |  |   |   | 22e. ADDRESS<br>16220 Frederick Avenue<br>Gaithersburg, Maryland 20877  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>9-7-83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ash Memorial Cemetery                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Sandy Spring, Montg., Md. |   |  |
| 24. FUNERAL DIRECTOR NAME<br>George R. Snowden   |  |   |   | 24b. ADDRESS<br>246 N. Washington St.<br>Rockville, Md. 20850   |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 9 1983  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |                                    |  |   |   |
|---|--|--|--|--|------------------------------------|--|---|---|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |                                    | 2b. HOUR   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 3. SEX   |  |                                    | 4. RACE  |   |   |
| Christopher Matthew Thompson  |  |  | Male   |  |                                    | Caus.  |   |   |
| 5. DATE OF BIRTH MONTH DAY YEAR   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |                                    | 7. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |
| Aug. 29, 1983   |  |  | YRS. MONTHS DAYS   |  |                                    | Montgomery MD.   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   |
| Maryland  |  |  | USA  |  |                                    |  |   |   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |   |
| Olney   |  |  | Montgomery General Hospital  |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |
| 13a. STATE  |  |  | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN  |   |   |
| Maryland  |  |  | Montgomery   |  |                                    | Wheaton  |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |                                    | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |
| Daryl Edward Thompson   |  |  | Christine Elizabeth Arrowood   |  |                                    | 13e. STREET ADDRESS  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT ADDRESS  |   |   |
|   |  |  |  |  |                                    |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                                    |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |                                    |  |   |   |
| IMMEDIATE CAUSE (a)   |  |  |  |  |                                    |  |   |   |
| 7611 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |                                    |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |                                    |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |                                    |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Innate</i>  |  |  |  |  |                                    |  |   |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)                                     |  |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |  |   |   |
| 22b. SIGNATURE  |  |  |  |  |                                    | 22c. DATE SIGNED   |   | 22d. ADDRESS  |
| Rafiq Mian, M.D.  |  |  |  |  |                                    |  |   | 6215 Greenbelt Rd., College Park, MD  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |
|   |  |  | 8/29/83  |  |                                    |  |   |   |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |
| Body Released to Hospital   |  |  |  |  |                                    | OCT 17 1983  |   | Rafiq Mian  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 25006   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Cecelia M. Thornton</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b HOUR<br><b>9 26 1983 1:45pm</b>  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 10 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>83</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Vermont</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Carriage Hill/Bethesda</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lawyer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>I.R.S.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br><b>D.C. 20015</b>   |  | 13c. CITY OR TOWN<br><b>Washington</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>5407 Nevada Ave., N.W. 9999</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Thornton</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Maria McGary</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-60-3161</b>  |  | 17. INFORMANT ADDRESS<br><b>Pauline Spafford. 5415 Conn. Ave., N.W. Wash., D.C.</b>  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac-Pulmonary Arrest</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary Arteriosclerosis with coronary thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>and Multiple Transient Ischemic Attacks</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>George A. Boinis, M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>9/26/1983</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George A. Boinis, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>5410 Conn. Ave., N.W. Wash., D.C.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>9/29/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Silver Spring Maryland.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Hawler's Sons Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |



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George A. Smith, Jr.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Annice R. Torbert</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Sept 10 83</b> 2b. HOUR <b>07:15</b> M                          |  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Cauc</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Oct 28 1940</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA - Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery City</b> MD   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Kensington</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Garden 189 Ctr</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>                           |  | 2b. KIND OF BUSINESS OR INDUSTRY <b>US Govt.</b>           |
| 13a. STATE <b>Md</b>  |   | 13b. COUNTY <b>Montg.</b>  | 13c. CITY OR TOWN <b>Kensington</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Frank Torbert</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Anna Dalrymple</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>  |   | 16b. SOCIAL SECURITY NO. <b>579-60-8134</b>  |  | 17. INFORMANT ADDRESS <b>Anne Leasure-niece- (same as 13e)</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable carcinoma of colon with vesico-colonic fistula</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>1539</b><br>(c) <b>Severe arteriosclerosis</b> |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Severe arteriosclerosis</b>   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/10 83</b> to <b>9/10 83</b> , that (I) (we) last saw the deceased alive on <b>9/10 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we said) (did not) view the body after death.                                 |   |  |  |  |  |
| 22b. SIGNATURE <b>B. N. ROSENBAUM, M.D.</b>   |   | DEGREE   |  | 22c. DATE SIGNED <b>9/10/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. N. ROSENBAUM, M.D.</b>  |   | 22e. ADDRESS <b>3720 FARRAGUT AVE. KENSINGTON, MD 20891</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |   | 23b. DATE <b>9-13-1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>                                       |  |
| 24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>  |   | ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE <b>De. o. o. o.</b>   |  |  |  |

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Mr. J. Edgar Hoover  
Director

US Govt.

10703 Lexington St., 20892

Baltimore

Anna

Torbert

Frank

(name as 130)

W/A

A

RECEIVED

NOV 10 1967



Wentwood R. George, Md.

Partial 9-13-1967  
1800 N.E. Ave.,  
Silver Spring, Md.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |                           |  |
|--|--|--|--|---|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mae N. Ullman</b>                          |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 22, 1983</b> |   | 2b. HOUR<br><b>7:05PM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 9, 1889</b>                                       |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bethesda Retirement Center</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>                           |                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |   |                           |  |
| 13a. STATE<br><b>D.C. 20024</b>  |  | 13c. CITY OR TOWN<br><b>Washington</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Meyer B. Newman</b>                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bettie UNKNOWN</b>   |  |   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>    |  | 16b. SOCIAL SECURITY NO.<br><b>579-60-0244</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Betty E. Ullman, Same as #13</b>                                 |                           |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2859</b> IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>congestive heart failure</b><br>Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause last.<br>(c) <b>anemia</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
**Cachexia, Organic brain syndrome**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19 83</b> , to <b>Sept 22, 1983</b> , that (I) (we) last saw the deceased alive on <b>Sept. 19 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Burt I. Feldman M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/22/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Burt I. Feldman, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>4000 Connecticut Avenue, N.W.<br/>Washington, D.C. 20008</b>  |  |  |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>9/26/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Maryland</b> |  |
| 24. FUNERAL HOME<br><b>Joseph Gawler's Sons, Inc.</b>         |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 28 1983</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Connel</b>                           |  |
| 5130 Wisconsin Avenue, N.W., Washington, D.C.                 |  |                             |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, a death certificate must be notified at once.



10. 10.10.1950 10.10.1950 10.10.1950

• C. H. P. 1910 •

Бюро . . . , *неизвестно*

Abstract

1. *Protein synthesis*  
 2. *Protein synthesis*

75-60-054

Figure 3. *Continued*

1111

45005 . D. D

not available.

• 10 •

Grey's

retrato de un niño abandonado

79010 454

Montgomery County,

40

•

$$M = \begin{pmatrix} 1 & 0 \\ 0 & 1 \end{pmatrix}$$

Page 55 continued

2208

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

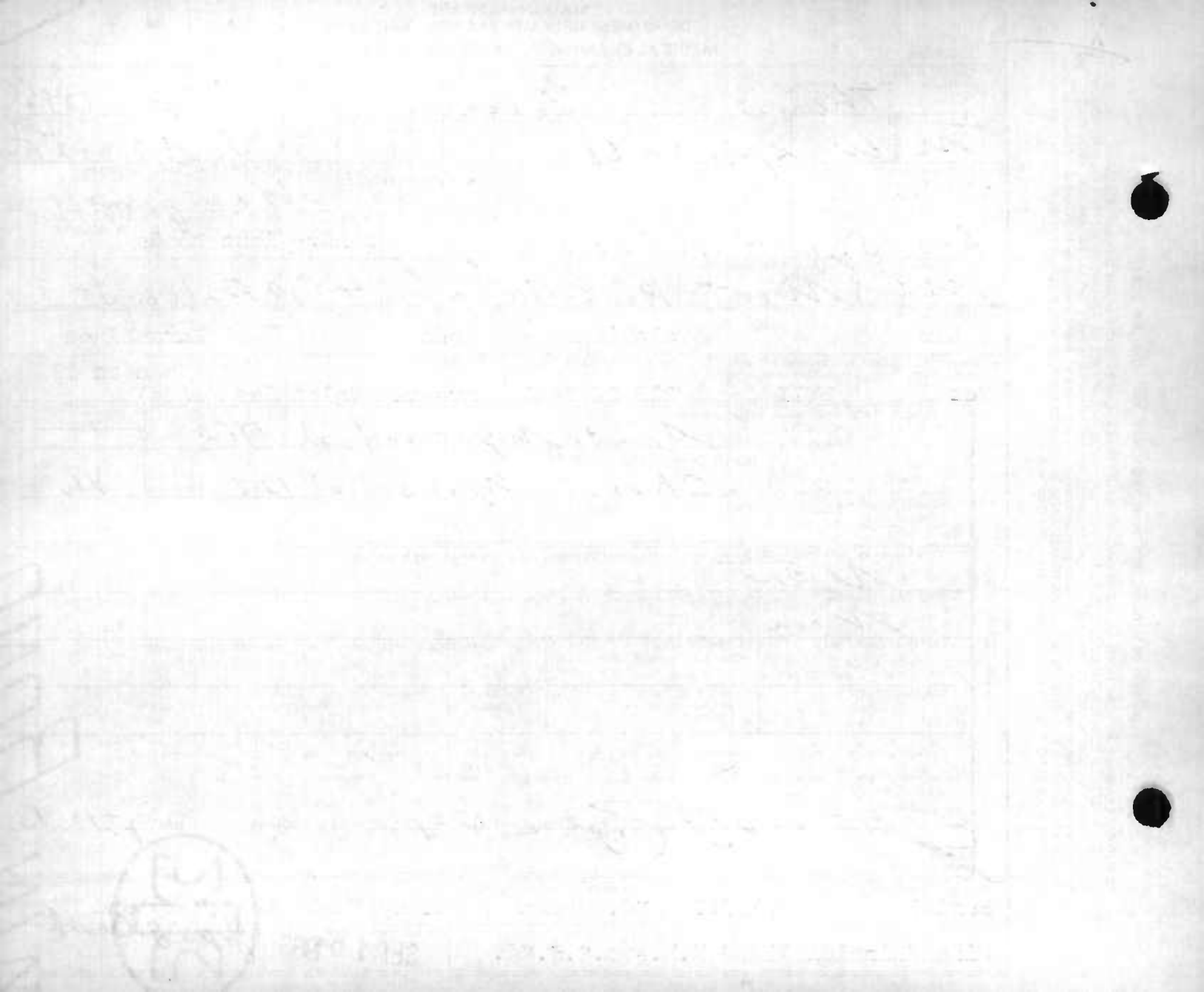
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25009

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |                     |   |   |   |   |
|--|---------------------|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Thomas Valanidas</b>  |                     |   | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 19 <b>83</b> HOUR <b>19</b> |   |   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH <b>April</b> DAY <b>13</b> YEAR <b>61</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>22</b> YRS.   | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>   | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>Sept</b> DAY <b>9</b> YEAR <b>83</b>           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>S. L. Spg.</b>   |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hosp.</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Baker-Giant Foods</b>   |   |
| 13a. STATE<br><b>MD</b>  |                     | 13b. COUNTY<br><b>Montg</b>   |   | 13c. CITY OR TOWN<br><b>Rockville</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Peter</b> MIDDLE <b>Valanidas</b> LAST <b>Valanidas</b>  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Karambines</b> LAST <b>Karambines</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>                                    |   |
| 16b. SOCIAL SECURITY NO.<br><b>225 26 3441</b>   |                     | 17. INFORMANT<br><b>Margaret Valanidas (Wife)</b>   |   | 17. ADDRESS<br><b>Same as 13E</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b><br><b>4291</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>Chronic Myocardial Dis</b><br>(c) _____  |                     |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Yrs</b>                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>  |                     |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>None</b>  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |   |   |   |   |
| ACTUAL SIGNATURE<br><b>[Signature]</b>   |                     | TITLE (SPECIFY)<br><b>Dep</b>   |   | MEDICAL EXAMINER<br><b>[Signature]</b>  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                     | ADDRESS   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                     | 23b. DATE<br><b>9/13/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cemetery</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Cheltenham, Maryland</b>   |                     | 23e. COUNTY<br><b>Md.</b>   |   | 23f. STATE<br><b>Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi</b>   |                     | ADDRESS<br><b>11800 N.H.Ave.S.S.Md.</b>   |   | 25a. DATE REC'D BY REGISTRAR<br><b>SEP 15 1983</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                     | DATE SIGNED<br><b>Sept 16 1983</b>  |   |   |   |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1 -  
STATE  
REGISTRAR

REG. NO.

|   |  |  |        |  |                   |   |       |  |  |   |  |  |
|---|--|--|--------|--|-------------------|---|-------|--|--|---|--|--|
| DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  | MIDDLE | LAST   | 2a. DATE OF DEATH |   | MONTH | DAY  | YEAR                                       | 2b. HOUR  |  |  |
| BENJAMIN (none) CORREA ValvesValdes   |  |  |        |  | Sept. 14          |   |       |  | 1983                                       | 7 <sup>14</sup> p.m.  |  |  |
| 3a. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |       | IF UNDER 1 YEAR  |  | IF UNDER 2 HRS.   |  |  |
| Male  |  | White  |        | Jan. 11 1983   |                   | -- YRS.   |       | 2 3  |  | HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |       |  |  |   |  |  |
| Washington D.C.   |  | U.S.A.   |        |  |                   | MONTGOMERY MD.  |       |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |       | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |
| Bethesda  |  | 5614 Jordan Road   |        |  |                   | None  |       | None   |  |   |  |  |
| 13a. STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS?  |       | 13e. STREET ADDRESS  |  |   |  |  |
| Maryland  |  | Montgomery   |        | Bethesda   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 5614 Jordan Rd. 20816  |  |   |  |  |
| 14. FATHER'S NAME   |  |  |        | 15. MOTHER'S MAIDEN NAME   |                   |   |       |  |  |   |  |  |
| FIRST   |  | MIDDLE   |        | LAST   |                   | FIRST   |       | MIDDLE   |  | LAST  |  |  |
| Mario   |  |  |        | Correa   |                   | Maria   |       | Angelica   |  | Valves  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |        | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT   |       |  |  |   |  |  |
| No  |  |  |        | N/A  |                   | None  |       | Father   |  |   |  |  |
|   |  |  |        |  |                   | Mario Correa Same as #13  |       |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u><br>7429<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>DEGENERATIVE NEUROLOGICAL DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |        |  |                   |   |       |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Hyperglycemia (DIABETES)</u>  |  |  |        |  |                   |   |       |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |   |       | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|   |  |  |        |  |                   |   |       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   |   |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
|   |  |  |        |  |                   |   |       |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                   |   |       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
|   |  |  |        |  |                   |   |       |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>BIRTH</u> 19____, to <u>Sept 14</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept 14</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |        |  |                   |   |       |  |  |   |  |  |
| 22b. SIGNATURE  |  |  |        | DEGREE   |                   |   |       | 22c. DATE SIGNED   |  |   |  |  |
| <u>Elliot Stephen GERSH</u>   |  |  |        | MD   |                   |   |       | Sept 15, 83  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |        | 22e. ADDRESS   |                   |   |       |  |  |   |  |  |
| <u>ELLIOT STEPHEN GERSH</u>   |  |  |        | <u>Georgetown Hospital</u>   |                   |   |       |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |        | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY                                  |       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |  |  |
| BURIAL  |  |  |        | Sept. 19, 1983   |                   | Cementerio General  |       |  | Santiago Chile/South America               |   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |        | 25a. DATE REC'D. BY REGISTRAR  |                   |   |       | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |
| <u>John F. DeVol</u>  |  |  |        | 2222 Wisconsin Washington D.C.   |                   |   |       | SEP 21 1983 <u>John J. Gansh</u>   |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



RECEIVED  
JAN 10 1963  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]  
[The body of the memorandum contains several paragraphs of text that are mostly illegible due to fading and bleed-through from the reverse side. Some words like 'Bureau', 'Washington', and 'subject' are faintly visible.]

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
JAN 10 1963  
[Handwritten notes and stamps at the bottom of the page, including a date stamp 'JAN 10 1963' and some illegible signatures or initials.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25011

|   |  |   |  |   |  |  |  |   |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR  |  | REG. NO.                                      |  |   |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   |  |  |  |   |  | 2a. DATE KNOWN<br>OF DEATH              |  | 2b. HOUR  |  |
| FIRST MIDDLE LAST<br>Antonette (NMI) Vinella  |  |   |  |   |  |  |  |   |  | MONTH DAY YEAR<br>9 1 83                |  | 19 10 30 AM                                     |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Cauc.                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 17, 1909   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>74s.             |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE<br>PRONOUNCED<br>DEAD          |  | 2d. HOUR  |  |
| 8. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD. |  | 2c. DATE<br>PRONOUNCED<br>DEAD  |  | MONTH DAY YEAR<br>9 1 83                |  | 2d. HOUR<br>5:15 PM                             |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>12631 Circle Drive                            |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Homemaker   |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Home    |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Rockville                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>12631 Circle Dr. |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Mastrangelo  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maria Dalena   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>579-22-6870         |  |
| 17. INFORMANT<br>ADDRESS Same as #13  |  |   |  | 17. INFORMANT<br>Vincent L. Vinella, Husband  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4140<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.<br>(b) <u>Coronary arteriosclerosis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |  |  |   |  |   |  |   |  |
| ACTUAL<br>SIGNATURE <u>John Tauber</u>  |  |   |  | TITLE (SPECIFY)<br>M.D.   |  |  |  | MEDICAL EXAMINER<br>DATE SIGNED 9-1-83  |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <u>John Tauber</u>   |  |   |  | ADDRESS <u>8218 Wisconsin Ave</u>   |  |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Entombment   |  |   |  |   |  |
| 23b. DATE<br>Sept. 6, 1983  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Robert A. Pumphrey Funeral<br>Homes, P.A., Rockville, MD.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1983   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John G. Smith</u>  |  |   |  |   |  |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25012

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ingrid A. Walton  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 5, 83   |  | 2b. HOUR<br>11:45 AM   |
| 3. SEX<br>Female   | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 28, 1929  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53<br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Berlin Germany  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7618 Winterberry Place |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>Montgomery  | 13c. CITY OR TOWN<br>Bethesda  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Fritz Aschinger  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ilse Scholler Harenflein                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>078-24-2121  | 17. INFORMANT (HUSBAND) ADDRESS<br>George E. Walton 7618 Winterberry Place, Bethesda, Maryland |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ovarian Cancer</u><br>1830<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> 19 <u>79</u> to <u>Sept 4</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept 1</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>James M. D'Angelo</u>   |   | DEGREE<br>MD.   |  | 22c. DATE SIGNED<br>9/7/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James M. D'Angelo M.D.  |   | 22e. ADDRESS<br>5401 Western Avenue N.W. Washington, D.C.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   | 23b. DATE<br>September 7, 1983  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia                   |  |
| 24. FUNERAL DIRECTOR<br>Robert A. Pumfrey Funeral Homes, P.A.<br>Bethesda, Maryland 20814  |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 9 1983   |  |  |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Period may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

| FOR STATE REGISTRAR   |  |                               |  |   |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH            |  |  |  |  |  |  |  |  |  | REG. NO. |  |  |  |  |  |  |  |  |  |
|---|--|-------------------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALMA Thompson WANNEN</b>   |  |                               |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 9-2-83 12 PM   |  |  |  |  |  |   |  |  |  | 2b. DATE PRONOUNCED DEAD 9-2-83 12 PM              |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b>              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1-24-03</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>80 YRS.</b>              |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD 9-2-83 12 PM  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.              |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b>  |  |                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b> |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                               |  |   |  |  |  |  |  | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |  |  |  |  |   |  |  |  | 13b. STREET ADDRESS <b>134 Monroe Street 20850</b> |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Montgomery</b> |  | 13c. CITY OR TOWN <b>Rockville</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Annie Elbon</b> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Howard Dorsey Thompson</b>  |  |                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>219-10-6255</b>  |  |  |  | 17. INFORMANT ADDRESS <b>Mrs. Carole Phillips Rockville, MD 20850</b>          |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>intracranial pressure</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>Syndrome of increased</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>acute intra cranial Hematoma</b> |  |                               |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                               |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>9-1-83</b>  |  |                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>acute INtra cranial Hematoma</b>   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8 09 1 1983</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fall in Kitchen</b>   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>  |  |                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>   |  |  |  | 21f. LOCATION <b>Rockville Montg. md</b><br>STREET <b>118 Monroe St apt 508</b><br>CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                               |  |   |  |  |  |  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John Tauber</b>   |  |                               |  | TITLE (SPECIFY) <b>Medical Examiner</b>   |  |  |  | DATE SIGNED <b>9-2-83</b>  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b>  |  |                               |  | ADDRESS <b>8218 Wisconsin Ave Bethesda md</b>   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |                               |  | 23b. DATE <b>September 6, 1983</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>     |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, INC.</b>  |  |                               |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 6 1983</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>John G. Smith</b>  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NOTED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHWH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25014

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |                     |   |   |   |   |
|--|---------------------|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ann Regina Ward</b>   |                     |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>Sept 1 1983</b> |   | 2b. HOUR<br><b>2:00 PM</b>  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>19</b> YEAR <b>1916</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>66</b> YRS.       | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3509 Twin Branches</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |   |
| 13a. STATE<br><b>MD</b>  |                     | 13b. COUNTY<br><b>Mont</b>  |   | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Benjamin</b> MIDDLE <b>F.</b> LAST <b>Calhoun</b>  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Dunnie</b> MIDDLE <b>S.</b> LAST <b>Baker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                     | 16b. SOCIAL SECURITY NO.<br><b>579-22-3464</b>  |   | 17. INFORMANT<br><b>Rockville, Md. 20851</b><br><b>Patricia A. Johnson 1008 Kennon Court</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>4291<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                     |   |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>None</b>  |                     |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>None</b>  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |   |   |   |   |
| ACTUAL SIGNATURE<br><b>John S. Rogers</b>  |                     | TITLE (SPECIFY)<br><b>Dep.</b>  |   | DATE SIGNED<br><b>Sept 3 1983</b>   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>John S. Rogers</b>   |                     | ADDRESS<br><b>1919 Seminary Rd. Silver Spring, Md.</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |                     | 23b. DATE<br><b>9/7/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>   |   |
| 23d. LOCATION<br>(CITY OR TOWN) <b>Rockville</b> COUNTY <b>Montgomery</b> STATE <b>Md.</b>   |                     | 23e. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1983</b>  |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Tyson Wheeler</b> ADDRESS <b>Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852</b>  |                     | 25. REGISTRAR'S SIGNATURE<br><b>John S. Rogers</b>  |   |   |   |

17

View

Eligible

Particular

None

77-2-2-2

Article A. Johnson 7008

1010-2-2-2-2, 1100-2-2-2-2

John, Moore

1010

1010-2-2-2-2, 1100-2-2-2-2

1010-2-2-2-2

1010-2-2-2-2, 1100-2-2-2-2



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |                     |  |   |   |   |   |  |  |   |  |  |
|---|---------------------|--|---|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Marjorie A. Warfield</i>   |                     |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <i>Aug 14/83</i>                             |   |   | 2b. DATE OF DEATH<br>MONTH DAY YEAR <i>Aug 17 1983</i>  |  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <i>Aug 17 1983</i>   |  |  |
| 3. SEX<br><i>F</i>  | 4. RACE<br><i>W</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>Dec 24 04 78</i> | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <i>78</i> YRS.                               | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>New York</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |  |
| 7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                     |   |   | 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>8817 2nd Ave</i> |  |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD</i> 13b. COUNTY <i>Mont.</i> 13c. CITY OR TOWN <i>Silver Spring</i>   |                     |  | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   |   | 12c. KIND OF BUSINESS OR INDUSTRY   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William H.J. SMITH</i>   |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Jennie Barker</i>             |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <i>No</i>   |  |  | 16b. SOCIAL SECURITY NO.<br><i>133-12-9869</i>  |  |  |
| 16c. INFORMANT<br><i>140 Linwood Ave. # B-12 Buffalo, N.Y.</i>  |                     |  | 16d. ADDRESS<br><i>Mrs. Ruth S. Neider-Sister 14209</i>                           |   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i><br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><i>None</i>  |                     |  |   |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><i>None</i>   |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |   |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                 |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                       |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |  |   |   |   |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br><i>John S. Rogers</i>   |                     |  | TITLE (SPECIFY)<br><i>MD</i>  |   |   | MEDICAL EXAMINER<br><i>John S. Rogers</i>   |  |  | DATE SIGNED<br><i>Aug 17 1983</i>   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><i>JOHN S. ROGERS</i>  |                     |  | ADDRESS<br><i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>                          |   |   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>  |  |  | 23b. DATE<br><i>8/19/83</i>   |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>PARKLAWN CEMETERY</i>  |                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>ROCKVILLE MONT MD.</i>           |   |   | 24. FUNERAL DIRECTOR<br>NAME<br><i>FRANCIS J. COLLINS</i>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>AUG 24 1983</i>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John S. Rogers</i>   |                     |  | 25c. ADDRESS<br><i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>              |   |   | 25d. DATE REC'D. BY REGISTRAR<br><i>AUG 24 1983</i>   |  |  | 25e. REGISTRAR'S SIGNATURE<br><i>John S. Rogers</i>   |  |  |



7

Wm. H. ...  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25016

1. FOR  
STATE  
REGISTRAR

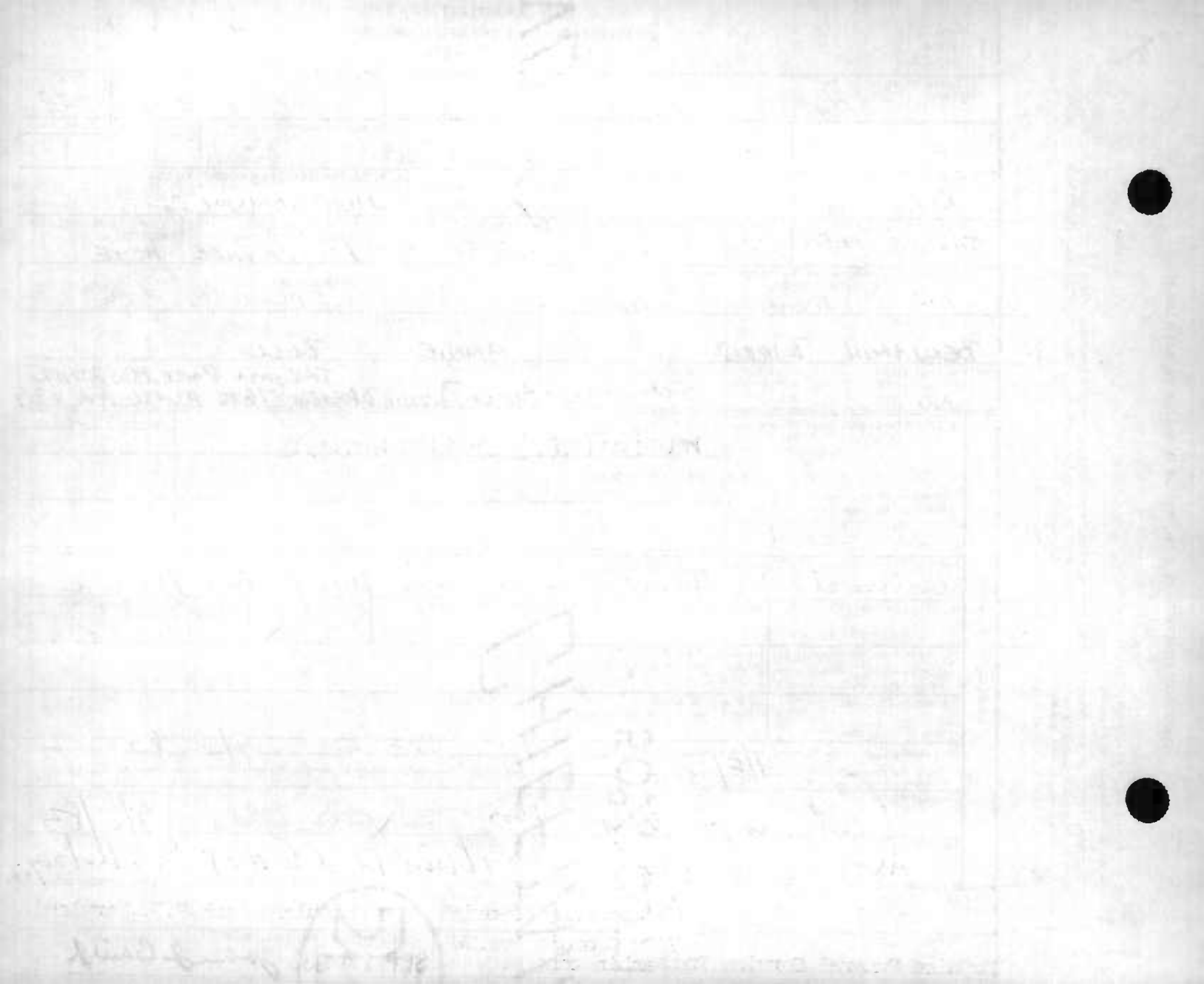
REG. NO.

|   |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Hattie Arbell Watts</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>9-6-83</i>                      |   |  | 2b. HOUR<br><i>7:40</i> M  |   |  |   |  |
| 3. SEX<br><i>F</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 27 00</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>83</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY</i> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>TAKOMA PARK</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>WASHINGTON ADVENTIST HOSP</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>HOME</i>   |   |  |
| 13a. STATE<br><i>MD</i>   |  |   | 13b. COUNTY<br><i>Mont.</i>  |   | 13c. CITY OR TOWN<br><i>Takoma Park</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>7600 Mapk Ave. #309</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>BENJAMIN BURRIS</i>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ANNIE BELL</i>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>578-42-1207</i>                         |   | 17. INFORMANT<br>ADDRESS<br><i>TAKOMA PARK, MD. 20912</i><br><i>SAUNDRA PARENTH, DAUGHTER 7600 MAPLE AVE. #309</i> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>metastatic Carcinoma</i><br><i>1991</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (g)<br><i>Arteriosclerotic Heart Disease, Hypertensive Disorder.</i>  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i> P.M.      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/3</i> 19 <i>83</i> , to <i>9/6</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>9/6/83</i> 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Antonio G. Uly</i>   |  |   | DEGREE<br><i>no</i>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><i>9/6/83</i>                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ANTONIO G. Uly</i>  |  |   | 22e. ADDRESS<br><i>831 Univ Blvd E #25 S.S. Unit 2090</i>              |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>Sept. 9, 1983</i>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Harmony Memorial</i>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Highland Park, P.G., Maryland</i>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McGuire Funeral Service, Inc</i>   |  |   | ADDRESS<br><i>7400 Georgia Ave. NW Washington, D.C.</i>                |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>SEP 14 1983</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Jan J. Conner</i>   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George C. Wenzel</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 6 83</b>   |  |  |  | 2b. HOUR<br><b>6:30AM</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 5, 1919</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Montgomery General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>steamfitter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>construction</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Laurel</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>16208 Dorset Road</b> <b>20707</b>                           |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George C. Wenzel</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jane Landis</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>WW 2 217 05 3837</b>  |  | 17. INFORMANT ADDRESS<br><b>Evelyn Wenzel same as above</b>                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Peritoneal Dialysis for Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitis.</b>  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 8</b> , 19 <b>83</b> , to <b>September 6</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>September 5</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Gregory H. Fisher MD</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>September 6, 1983</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gregory H. Fisher</b>  |  |   |  | 22e. ADDRESS<br><b>13-15 E. DEER PARK DR. GAITHERSBURG, MD.</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Sept 9, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ivy Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Maryland</b>                  |  |  |  |
| 24. FUNERAL HOME (TYPE OR PRINT)<br><b>W. J. ...</b>   |  |   |  | ADDRESS<br><b>Laurel, Md</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 13 1983</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>G. ...</b>  |  |

#### 24. Formula

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25018

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |  |  |  |  |
|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Randolph Williams</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/21/83. Sept. 21, 83</b>         |   |   | 2b. HOUR<br><b>12:40 AM</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-7-17</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Camelie, GA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Mont. Co.</b> MD.                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unknown</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |
| 13a. STATE<br><b>D. C.</b>   |  | 13b. COUNTY<br><b>Washington</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13c. STREET ADDRESS<br><b>600 13th St. N.W. #105</b>                                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>158-09-1589</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Ms. Brenda Williams/daughter/2 E 48th St.<br/>New York, N.Y. 10016</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br><b>4039</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Orthopedic accident</b>   |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3/9 83</b><br>P.M. 19 |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/17/83</b> to <b>8/21/83</b> , that (I) (we) last saw the deceased alive on <b>9/17/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not attend, write the date and hour of death.)                                    |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Thos G. Ward</b>  |  |   |   |   |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>9/22/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thos G. Ward, 6116 Robinwood, Bethesda, Md 20817</b>   |  |   |   |   |   | 22e. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>9-28-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Daytona Beach, Fla.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John T. Rhines Co., 3015 12th St. N.E., D.C.</b>  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 27 1983</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THIS DEED WAS RECORDED IN THE PUBLIC RECORDS OF THE  
COUNTY OF [illegible] STATE OF [illegible] ON [illegible]  
AT [illegible] O'CLOCK [illegible] P.M. 19[illegible]  
BY [illegible] CLERK OF THE COURT

WITNESSES MY HAND AND SEAL OF OFFICE  
THIS [illegible] DAY OF [illegible] 19[illegible]  
AT [illegible] IN THE COUNTY OF [illegible] STATE OF [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 521-1234.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.<br>25019   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1 DECEASED NAME FIRST MIDDLE LAST Sadie A. Williams   |  |  |  | Sept. 15/1983 12:15 P.M.  |  |   |  |
| 3 SEX Female  |  | 4 RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR June 12, 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.  |  |
| 10 CITY OR TOWN OF DEATH Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY At Home   |  |
| 13a. STATE D.C. 20008   |  | 13b. COUNTY ---  |  | 13c. CITY OR TOWN Washington  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST Maximillian -- Alexander   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah E. Woodley   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |   |  |
| 16b. SOCIAL SECURITY NO 577-09-8529   |  | 17 INFORMANT ADDRESS Dr. Maximillian M. Alexander, Same address as #13.  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Stroke  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15d |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cerebrovascular disease   |  |  |  |   |  |   | 20 years   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10 Sept 1983 to 15 Sept 1983, that (I) (we) lost saw the deceased alive on 10 Sept 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22a. SIGNATURE Paul T. Nours MD   |  |  |  | DEGREE MD   |  | 22c. DATE SIGNED 15 Sept 83   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Paul T. Nours MD  |  |  |  | 22e. ADDRESS 50 W. Edmonston Dr., Rockville, Md.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 9/19/83  |  | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Pk.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland   |  |
| 24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR SEP 20 1983   |  | 25b. REGISTRAR'S SIGNATURE John J. Connel   |  |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016   |  |  |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMMA B. WILSON</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 9-22-83 2b. HOUR 12:15 AM   |  |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR 1-02-89  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. 413 MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE/CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper Railway Express</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Silver Spring</b>   |  | 13d. STREET ADDRESS <b>9504 Monroe Street 20910</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>James M. Nuse</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie R. Fry</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |  |
| 16b. SOCIAL SECURITY NO. <b>714-03-2700</b>   |  | 17. INFORMANT ADDRESS <b>Dorothy French Sister Same as 13</b>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4349</b> IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>massive cerebral infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>systemic hypertension -</b>            |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>cardiac aneurysm</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>9/18/83</b> to <b>9/22/83</b> , that (we) lost <b>we</b> saw the deceased alive on <b>9/21/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>John M. Nuse</b>  |  | DEGREE <b>MD</b> <b>DR. DRAPER</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>9/22/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Huyar, M.D.</b>   |  | 22e. ADDRESS <b>HOLY CROSS HOSPITAL</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Sep. 24 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Reformed Cem</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Jefferson Frederick Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |   |  |  |
|---|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THOMAS PILMORE WYNKOOP, JR.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 15 1983</b>           |   |  | 2b. HOUR<br><b>6:00 P<sub>M</sub></b>   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DECEMBER 27 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR</b> COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>                            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. NAVY</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS PILMORE WYNKOOP</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA GRACE SOUDER</b> |   |  | 13e. STREET ADDRESS<br><b>10500 ROCKVILLE PIKE, APT 1121</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>1915-1949</b>   |   | 16c. SOCIAL SECURITY NO.<br><b>571-40-8370</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>FLORENCE G. WYNKOOP, 10500 ROCKVILLE PIKE,</b>                                 |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>THALAMIC INTRACEREBRAL HEMORRHAGE</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  | APR. 1121, ROCKVILLE, MD 20852<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (u) (this hospital) attended the deceased from <b>SEPTEMBER 14, 1983</b> , to <b>SEPTEMBER 15, 1983</b> , that (we) last saw the deceased alive on <b>SEPTEMBER 15, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) (did) (did not) view the body after death.                             |  |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Richard Erwin</i> M.D.<br>DEGREE   |  |  |   |   |  | 22c. DATE SIGNED<br><b>16 Sept 83</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD ERWIN, LT, MC, USNR</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,<br/>NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b> |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>9/19/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem. Arlington, Virginia</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons, Inc.</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 22 1983</b>   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>  |  |  |   |   |  | 25c. REGISTRAR'S NAME<br><b>John J. Smith</b>   |   |  |  |

BP

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



[Faint, mostly illegible text covering the main body of the page, possibly a report or letter.]

Very truly yours,  
[Signature]  
[Name]  
[Title]  
[Address]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1. THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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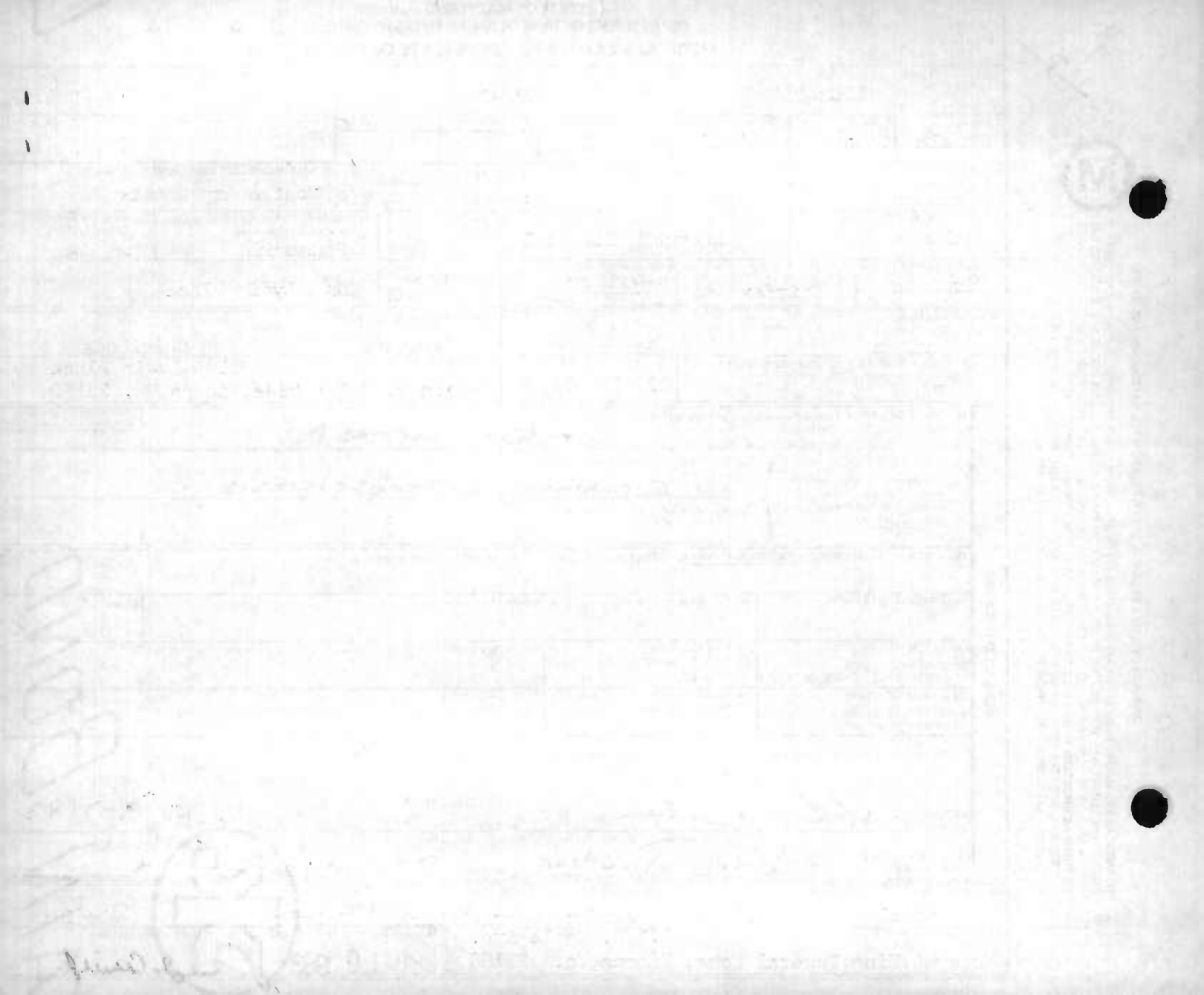
1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
|--|-----------|--|--|---|--|---|--|--------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |           | FIRST  |  | MIDDLE  |  | LAST  |  | 2b. DATE KNOWN OF DEATH              |  | MONTH                    |  | DAY   |  | YEAR |  | 2d. HOUR |  |
| LUCRECIA   |           | NMN  |  | ZALDUMBIDE  |  |   |  | 9                                    |  | 7                        |  | 19    |  | 83   |  | 4:17P    |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| Female   | Caucasian | 11-20-1900   |  | 82  |  |   |  |                                      |  | 9                        |  | 7     |  | 19   |  | 83       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |           | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |  |       |  |      |  |          |  |
| Ecuador  |           | Ecuador  |  |   |  |   |  | Montgomery County                    |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Bethesda   |           | Suburban Hospital  |  | Housewife   |  | Own Home  |  |                                      |  |                          |  |       |  |      |  |          |  |
| 13a. STATE   |           | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                          |  |       |  |      |  |          |  |
| Virginia   |           | Fairfax  |  | Vienna  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 2206 Lydia Place                     |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |           | 15. MOTHER'S MAIDEN NAME                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                        |  |                          |  |       |  |      |  |          |  |
| Enrique  |           | Genoveve   |  | No  |  | 230-11-5711   |  | Fabian R. Zaldumbide                 |  |                          |  |       |  |      |  |          |  |
|  |           | Chiriboga  |  |   |  |   |  | 2206 Lydia Place                     |  |                          |  |       |  |      |  |          |  |
|  |           |  |  |   |  |   |  | Vienna, Va. 22180                    |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| PART 1 DEATH WAS CAUSED BY:  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 4140 IMMEDIATE CAUSE (a) Cardiac Arrest.   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| (b) Coronary arteriosclerosis.   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| (c)  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 20. AUTOPSY?   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21b. TIME OF INJURY  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| HOUR A.M. MONTH DAY YEAR   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| P.M. 19  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21f. LOCATION  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| CITY OR TOWN COUNTY STATE  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| TITLE (SPECIFY)  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| M.D. MEDICAL EXAMINER  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| DATE SIGNED 9-7-83   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE John Tauber   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| ADDRESS 8218 Wisconsin Ave   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Burial   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 23b. DATE  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Sept. 10, 1983   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Fairfax Memorial Park  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 23d. LOCATION  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| CITY OR TOWN COUNTY STATE  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Fairfax, Virginia  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| NAME ADDRESS   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 171 W. Maple Ave.  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Money & King Funeral Home, Vienna, Va. 22180   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 25a. DATE REC'D. BY REGISTRAR  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| SEP 19 1983  |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 25b. REGISTRAR'S SIGNATURE   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |
| John J. Connel   |           |  |  |   |  |   |  |                                      |  |                          |  |       |  |      |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |                                   |  |
|---|--|--|---|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR                          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |   | HOURS MIN.                        |  |
| Edna K. Zugel   |  | 9/17/83  |   | 12:30a.                           |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR                |  |
| Female  | White  | MONTH DAY YEAR   | 91  | IF UNDER 24 HRS.                  |  |
| Feb. 17, 1892   |  |  |   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                   |  |
| Pennsylvania  | U.S.A.   |  | Montgomery MD.  |                                   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Potomac   | 9000 Congressional Court   | Secretary  |   | --Service Selective--             |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS               |  |
| Maryland  | Montgomery   | Potomac  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 9000 Congressional Court          |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   |                                   |  |
| Conrad  | Kopp   | No   |   |                                   |  |
| 16b. SOCIAL SECURITY NO.  | 17. INFORMANT  | ADDRESS  |   |                                   |  |
| 577-26-1942   | Mrs Mary J. Bastian  | 9000 Congressional Potomac, Md.  |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |                                   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |                                   |  |
| IMMEDIATE CAUSE (a) Generalized Atherosclerosis - incl. Arrhythmia  |  |  |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Angiodysplasia - Rt colon - with GI bleeding   |  |  |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |  |   |                                   |  |
| Vascular tract - atherosclerosis - osteoporosis - osteoarthritis - cerebrovascular accident   |  |  |   |                                   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                   |  |
|   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |                                   |  |
|   | P.M. 19  |  |   |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |                                   |  |
|   |  |  |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-6-82, 1982, to 9-10, 1982, that (I) (we) last saw the deceased alive on 8-29, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death. |  |  |   |                                   |  |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED                  |  |
| Richard B. Perry, M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   | 9/19/1983                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |                                   |  |
| Richard B. Perry, M.D.  |  | 1145--19th St., N.W. Wash., D.C.   |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                   |  |
| Burial  | Sept. 20, 1983   | Mt. Olivet Cemetery  | Washington, D.C.  |                                   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE        |  |
| Joseph Gawler's Sons  |  | 5130 Wisconsin Ave. N.W. Washington, D.C.  |   | SEP 23 1983 John J. Carroll       |  |

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DATE: 10/10/55

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23/5/25/6

U.S. DEPT. OF JUSTICE

1. The first step is to identify the problem or question that needs to be answered.

CONFIDENTIAL

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09-11-2011 05:17

2.1. *notations*

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